

**Authorization
to Treat Minor
Patient in the
Absence of
Parent or
Legal
Guardian**

I, _____, the parent or legal guardian
(name of parent or legal guardian)

of _____, hereby authorize
(name of patient/child)

_____ to accompany my above-named
(name of person bringing child to the office)

child to office visits with

Richard W Swails, DPM

Bilal Master, DPM

and to consent to the examination and/or treatment of my child.

This authorization:

is effective for the following date only: _____

is effective from for visits from _____ to _____

is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing
to the above-named physician.

Richard W Swails, DPM
Jasmin Mansoori, DPM

Witness Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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