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.

Witness Signature_____Date_____

Parent/Guardian Signature_____Date_____

Richard W Swails, DPM
Bilal Master, DPM

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