Authorization to Treat Minor Patient in Absence of Parent/Guardian

Chapin Pediatrics, PA

119 Amicks Ferry Road Chapin, South Carolina 29036

I am the parent/legal guardian of the minor child named below. I hereby request, authorize, and consent to the examination and/or treatment of my child by

____ during office visits.
(Provider's name)

This authorization is effective: **(Check one and indicate date(s), if applicable.)**

- ▫ **Only on:** ____
  Month/day/year

- ▫ **From:** ____________________________ to ______________________.
  Month/day/year Month/day/year

- ▫ **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.

____
Patient's Name

____
Parent/Guardian's signature

Date:_____________________________