Authorization to Treat Minor Patient in Absence of Parent/Guardian

Chapin Pediatrics, PA

723 Chapin 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:_____