Podiatry Associates of Cincinnati
Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of minor patient: _____ Date of Birth: _____

I certify that I am the parent and/or legal guardian of _____
(*Name of child)*

☐ I authorize _____ to bring my child to office visits with Dr. _____
(name of person bringing child to office) *(name of physician)*

☐ I authorize the minor child named above to come alone to office visits with Dr. _____
(name of physician)

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

This authorization:

☐ is effective on _____.

☐ is effective from _____ to _____.

☐ is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Home phone number _____ Office phone number _____

Cell phone number _____ Other phone number _____

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

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Revised February 2010