TREATING MINOR WITHOUT A PARENT OR LEGAL GUARDIAN

Patient Name: _____ Date of Birth: _____

I, _____ (parent or legal guardian), authorize treatment of the minor patient when accompanied by the following decision-making persons at their appointments:

Name: _____ Relationship to patient: _____

Date of Birth: _____ Phone: _____

Name: _____ Relationship to patient: _____

Date of Birth: _____ Phone: _____

Name: _____ Relationship to patient: _____

Date of Birth: _____ Phone: _____

Name: _____ Relationship to patient: _____

Date of Birth: _____ Phone: _____

I understand that I may revoke this authorization at any time by notifying Mt Spokane Pediatrics in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

_____ _____

Parent or Legal Guardian Date