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## AUTHORIZATION FOR TREATMENT OF A MINOR

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Legal guardian: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Option one:**

I, \_\_\_\_\_, give consent for the minor,  
\_\_\_\_\_, to be seen without my presence and make their own medical decisions.

**Option two:**

I, \_\_\_\_\_, give permission to \_\_\_\_\_, to act as my  
representative and make the medical decisions for \_\_\_\_\_.

\_\_\_\_\_ For this date only

\_\_\_\_\_ For all appointments.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date