Karina Loya, D.P.M.
Steven A. Sterriker, D.P.M.
Nealand O. Willingham II, D.P.M.
James P. Townson, Jr., D.P.M.

AUTHORIZATION TO TREAT A MINOR IN THE ABSENCE OF PARENT/GUARDIAN

Minor Patient's Name:_____ D.O.B.:_____

I certify I am the parent and/or legal guardian of _____.
Name of Child

I authorize _____ to bring my child to office visits at Waco Foot & Ankle
Name of Person Authorized to Bring Child to Office

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

OR FOR AN OLDER MINOR WHO DRIVES OR MAY COME ALONE:

I certify I am the parent and/or legal guardian of _____.
Name of Child

I authorize the above named minor to come alone (without parent/guardian in attendance) for office visits at Waco Foot & Ankle and I consent to the examination and/or treatment of my child.

This authorization is effective: (select and complete all that apply)

- ○ On _____
- ○ From _____ to _____
- ○ Until revoked by me in writing

I reserve the right to revoke this authorization by providing written notification to the office and/or physician.

_____ _____
Signature of Parent or Legal Guardian Relationship to Patient

_____ _____
Witness Signature Date

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