St. Elizabeth
PHYSICIANS

AUTHORIZATION TO TREAT MINOR IN ABSENCE OF PARENT/GUARDIAN

I, ________________________________, the parent and/or legal guardian
(Name of Parent/Guardian)

of _________________________________, date of birth ________, hereby
(Name of Patient) (Date of Birth of Patient)

authorize___________________________________ to accompany the
(Name of Person Bringing Patient to the Office)

above-named patient to the office for visits with ______________________.
(Name of Physician)

and do consent to the examination and /or treatment (including immunizations) of the patient during the office visit(s) for all medical treatment that may be required for our child during our absence.
It is understood that this authorization is given in advance of any such medical treatment, but it is given to provide authority and power on the part of the individual identified above in the exercise of his or her best judgment upon the advice of any such medical personnel. I agree to assume financial responsibility for all expenses of such care.

This authorization:

- ❑ Is effective ***only*** on ______________________________________
(month / day / year)
- ❑ Is effective 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.

____________________________ ____________________________
SIGNATURE OF PARENT/GUARDIAN SIGNATURE OF WITNESS

____________________________ ____________________________
DATE DATE

Updated 1/26/21