Choice Pediatrics

TREATMENT AUTHORIZATION FOR MINORS

We recognize that parents may not always be able to be available or present during needed treatment of their young child or teen. This form addresses the situation when your child needs to be seen and has come in either alone or accompanied by another adult/guardian.

I, (Parent/Guardian) ____
(Picture ID must be on file)

of (child's name) ____

Child's Date of Birth____

authorize my above named child to be treated: [ ]UNACCOMPANIED [ ] ACCOMPANIED

If child must be accompanied, authorized persons are:

- ____(must have picture ID at EACH visit)
- ____(must have picture ID at EACH visit)
- ____(must have picture ID at EACH visit)
- ____(must have picture ID at EACH visit)

____ ___________________________

Parent/Guardian Signature **Date**