Town Center Foot & Ankle

Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of Patient: _____ Date of Birth: _____

I certify that I am the parent and/or legal guardian of _____.
(name of child)

- ☐ I authorize _____ to bring my child to office visits with
  (name of person bringing child to office)
  Dr. Stephen Eichelsdorfer.

- ☐ I authorize the minor child named above to come alone to office visits with Dr. Stephen Eichelsdorfer.

I consent to the examination and treatment of my child.

This authorization:

- ☐ Is effective on _____.
- ☐ Is effective from _____ to _____.
- ☐ Is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Name: _____ Phone Number: _____

Address: _____

Please submit with copy of parent/guardian's driver's license.

I reserve the right to revoke this authorization at any time by writing to the above named physician.

Parent/Guardian Signature: _____ Date: _____