CENTER FOR FOOT AND ANKLE RESTORATION
Charles E. Cook, M.D.
John M. Noack, M.D.
www.footankledallas.com
Phone: 214-265-7175
Fax: 214-691-5940

Parent/Legal Guardian Authorization for Medical Services

Please mark one of the options below if you wish to authorize our clinic to provide medical services to your child in your absence.

[] I hereby give authorization for my child to be evaluated by a physician of Orthopedic Specialists and for the physician to perform medical evaluation without a parent or legal guardian present.

[] I hereby give authorization for my child to be evaluated by a physician of Orthopedic Specialists and for the physician to perform medical evaluation without a parent or legal guardian present, as well as for the physician to perform non-invasive treatment including x-rays and cortisone injections, and report the findings and treatment plan to myself.

Patient name: _____ Date:_____

Parent/Legal Guardian Name:_____

Parent/Legal Guardian Signature:_____