PERMISSION TO TREAT A MINOR WITHOUT A PARENT/GUARDIAN PRESENT

Endwell Family Physicians, LLP, must receive permission from a child's parent or legal guardian before providing treatments for most injuries or illnesses that are non-life threatening. This form gives us legal permission to treat your child in case you cannot accompany him/her to the office for treatment.

PATIENT NAME: _____

PATIENT'S DATE OF BIRTH: _____ **TODAY'S DATE:** _____

I, the undersigned, parent or legal guardian of _____, a minor, do hereby authorize the following person(s)

(1) Name: _____ Phone: _____
Relationship:_____

(2) Name: _____ Phone:_____
Relationship:_____

to arrange for and authorize routine and emergency treatment at Endwell Family Physicians. This authorization is effective through _____. If left blank it will expire one year from "today's date." Date

I acknowledge I am responsible for all reasonable charges in connection with the care and treatment rendered.

- Please send the insurance card and co-pay (if applicable) to the appointment.

If there are any services that you do not consent to in your absence, please list:

_____

_____

Parent or Legal Guardian: _____

Print Complete Name

Please complete in ink

_____

Signature

August 2016/pr