SUMMIT PEDIATRICS MEDICAL GROUP

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Authorization to Treat Minor Patient in Absence of Parent/Guardian

I,_____, the parent and legal guardian of _____,
List names
_____,
_____,
_____,

hereby authorize _____ _____
(name of person bringing child to office) (name of person bringing child to office)

to accompany my above-named child to office visits with Summit Pediatrics and consent to the examination and/or treatment of my child during office visits. This authorization includes necessary bloodwork as well as the administration of any recommended immunizations.

This authorization:

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

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

_____ _____
(Signature of Witness) (Signature of Parent/Guardian)

_____ _____
(Date) (Date)