TALLAHASSEE PODIATRY ASSOCIATES FOOT & ANKLE CENTER

1866 Buford Blvd
Tallahassee, FL 32308
(P) 850.878.6998
(F) 850.656.9293
www.tlhpodiatry.com

Authorization to Treat Minor Patient in Absence of Parent/Guardian

Patient Name (Minor): _____ Date of Birth: _____

I certify that I am the parent and/or legal guardian of _____
(*Name of Patient*)

☐ I authorize _____ to bring my child to office visits with Dr. _____
(Name of Authorized Person to Bring Minor) *(Physician's Name)*

☐ I authorize the above named minor child to come alone to office visits with Dr. _____
(Physician's Name)

and I consent to the examination and/or 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:

Home Phone: _____ Cell Phone: _____ Office Phone: _____

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

Parent/Guardian Signature: _____ Date: _____

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