# Authorization for Evaluation and/or Treatment of a Patient Unaccompanied by their Legal Guardian and/or POA

A Legal Guardian and/or Power of Attorney (POA) *MUST* accompany patients to consent for all medical and/or surgical treatment provided by Dr. Charles Pittle or Dr. Amy Bodart.

Please complete this form if the patient will be coming for a visit, for treatment or a procedure, without their Legal Guardian and/or Power of Attorney (POA) present.

**Patient's Full Name:**_____

DOB:_____ Phone:_____

Address:_____

City, State & Zip: _____

## Authorization for other individual to accompany patient.

Written Consent is valid for the time period of **:** _____ **to** _____**.** (Not to exceed one year) at which time a new consent will be required. This consent may be revoked by me at any time in writing.

**I authorize** _____, _____,
**(Full name of person being authorized)** **(Relationship to patient)**

to give consent for all medical and/or surgical treatment by Dr. Charles Pittle and/or Dr. Amy Bodart on behalf of myself for the patient listed above.

The above named individual may also receive test results and additional information pertinent to the care and treatment of this patient.

I understand that I am still financially responsible for all medical expenses incurred by the patient during these appointments.

_____ _____
**Signature of Legal Guardian and/or Power of Attorney (POA)** **Date signed**

_____ _____
**Printed name of Legal Guardian and/or Power of Attorney (POA)** **Phone #** (in case of Emergency)

**This consent is valid for the specified time period and/or has a maximum effective time period of one (1) year from the date signed.**