Authorization for Evaluation and/or Treatment of a Minor Child/Patient Unaccompanied by a Parent and/or Legal Guardian

A Parent or Legal Guardian *MUST* accompany any child under 18 years of age to consent for all medical and/or surgical treatment provided by Dr. Charles Pittle or Dr. Amy Bodart.

Please complete this form if your child will be coming for a visit, for treatment or a procedure, without a Parent or legal Guardian present.

Minor Patient's Name:_____ DOB:_____

Address:_____

City, State & Zip: _____

Phone:_____

Authorization for other individual to accompany minor patient under 18 years of age.

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 my child listed above.

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

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

_____ _____
Signature of Parent and/or Legal Guardian **Date signed**

_____ _____
Printed name of Parent and/or Legal Guardian **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.