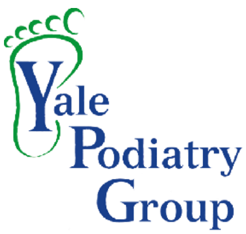

364 East Main Street
Ansonia, CT 06401

4 Corporate Drive Suite 384
Shelton, CT 06484

P: 203-734-4806

Authorization to Treat Minor Patient in Absence of Parent/Guardian

I, _________________________________, the parent and legal guardian of __________________________, herby
(name of parent) (name of child)

authorize___________________________________ to accompany my above-named child to office visits with
(name of person bringing child to the office)

________________________ and to consent to the examination and/or treatment of my child.
(name of physician)

This authorization:

☐ Is effective on _____________________________________.
(month/day/year)

☐ Is effective from _____________________________________ to _____________________________________.
(month/day/year) (month/day/year)

☐ Is effective until revoked by me in writing.

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

Witness Signature: ____Date: ______________

Parent/Guardian Signature: ____ Date: ______________