MISSOULA Bone & Joint & Surgery Center

**AUTHORIZATION TO TREAT MINOR PATIENT**
**IN ABSENCE OF PARENT/GUARDIAN**

I, _____, the parent and legal guardian of _____,
(name of parent/guardian) (name of child)

hereby authorize _____ to accompany my above-name child to
(name of adult accompanying child to office)

office visits with _____ and to consent to the examination and/or
(name of physician or physicians)

treatment of my child during the office visits.

This authorization:

☐ is effective only 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-name physician.

I understand that my child (under 18 years of age) cannot attend his/her appointment without the accompaniment from the adult listed above.

_____ _____
Signature of Parent/Guardian Date Signature of Witness Date

2360 Mullan Rd Ste C
Missoula, MT 59808 406-721-4436 Phone 406-721-6053 Fax