

**Authorization to Treat Minor Patient in Absence of Parent/Guardian**

Name of Minor Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I certify that I am the parent and/or legal guardian of \_\_\_\_\_  
(name of child)

I authorize \_\_\_\_\_ to bring my child to office visits with  
(name of person bringing child to office)

Dr. Mark R. Williams     Dr. Christopher T. Hehemann     Dr. David T. Hehemann  
and I consent to the examination and treatment of my child.

I authorize the minor child named above to come alone to office visits with

Dr. Mark R. Williams     Dr. Christopher T. Hehemann     Dr. David T. Hehemann  
and I consent to the examination and treatment of my child.

This authorization:

is effective on \_\_\_\_\_

is effective from \_\_\_\_\_ to \_\_\_\_\_

is effective until revoked by me in writing.

Parent/Guardian Contact Information:

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_