

# Consent for Procedure/Treatment of Minor Child

I authorize and direct \_\_\_\_\_, MD, and his or her assistants as necessary to perform quality care, procedure/ treatment(s) upon my minor child.

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security#: \_\_\_\_\_

This authorization is for \_\_\_\_\_ date of treatment.

The person(s) authorized to request treatment on my behalf is/are

(1) \_\_\_\_\_ Relationship to patient \_\_\_\_\_

(2) \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Parent or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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- **Signature of parent must match the signature on file in our office**
- **If a patient has never been seen in our office a copy of driver license must be attached**
- **If legal guardian is signing a copy of guardianship papers must be on file in our office**