

AUTHORIZATION FOR TREATMENT OF A MINOR

Patient Name: _____ Date Of Birth: ____ / ____ / ____

Address: _____ Soc.Sec.No: ____ / ____ / ____

City: _____ State: ____ Zip: _____ Telephone #: (____) ____ - ____

Please indicate PARENTS name and information authorizing visit below.

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (____) ____ - ____

Relationship To Patient: _____

I _____ authorize treatment for _____

to be seen at Bee Caves Medical without being present at the time of visit. I understand that the patient mentioned above will receive an evaluation and treatment by a Bee Caves Medical physician.

Patient Name

DOB

Patient Signature

OFFICE USE ONLY

Please indicate what type of consent was given:

- Verbal Consent (Phone Conversation)
- In Person
- Written Consent

Office Staff Sign: _____

Office Staff Print: _____

Med Staff Sign: _____

Med Staff Print: _____