

**Podiatry Associates of Cincinnati**  
**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 Dr. \_\_\_\_\_  
(name of person bringing child to office) (name of physician)

☐ I authorize the minor child named above to come alone to office visits with Dr. \_\_\_\_\_  
(name of physician)

and I consent to the examination and/or treatment of my child.

This authorization:

☐ is effective on \_\_\_\_\_.

☐ is effective from \_\_\_\_\_ to \_\_\_\_\_.

☐ is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Home phone number \_\_\_\_\_

Office phone number \_\_\_\_\_

Cell phone number \_\_\_\_\_

Other phone number \_\_\_\_\_

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

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

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_