

*The Wolff Center for  
Child & Adolescent Health*

**AUTHORIZATION FOR TREATMENT OF MINORS**

I, \_\_\_\_\_, being the parent or legal guardian of the following  
(Parent/Guardian Name)

minor, \_\_\_\_\_ (Date of birth)  
(Patient full legal name)

and having the legal right to consent for medical treatment for the above named minor,  
do hereby assign this right of consent to:

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Name) (Relationship to patient) (Phone #)

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Name) (Relationship to patient) (Phone #)

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Name) (Relationship to patient) (Phone #)

for the period beginning \_\_\_\_\_, 20\_\_\_\_. This consent will be active until we  
(Date)  
are notified in writing or a new authorization is signed.

\_\_\_\_\_  
(Signature of parent/guardian) (Date)

\_\_\_\_\_  
(Witness) (Date)