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, _____ _____
(Patient full legal name) (Date of birth)

and having the legal right to consent for medical treatment for the above named minor, do herby 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)