

Alaska Foot & Ankle Specialists
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Specialists

AUTHORIZATION TO TREAT MINOR IN ABSENCE OF PARENT/GUARDIAN

Name of minor patient: _____ DOB: _____
PLEASE PRINT

I certify that I am the parent and/or legal guardian of _____.

I authorize _____ to bring my child to office visits at Alaska Foot & Ankle Specialists and to consent to the examination and/or treatment of my child.

_____ is attending the appointment alone. I authorize and consent to the examination and/or treatment of my child.

Please use the following credit card for payment and provide copy of bill and receipt:

Card # _____ Exp. Date: _____

Name on card: _____ Security Code: _____

This authorization:

is effective on _____.

is effective from _____ to _____.

is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time in writing submitted to Alaska Foot & Ankle Specialists.

PRINT NAME PARENT/GUARDIAN Date: _____

SIGNATURE

PICTURE ID OR COPY OF MUST BE SUBMITTED WITH THIS FORM