Parental Authorization to Treat A Minor

The undersigned hereby consents on behalf of the below named minor less than eighteen to the medical diagnosis or treatment to be performed by Stonebriar Pediatrics.

Minors Name: _____ DOB: _____

I, _____(guardian) give Stonebriar Pediatrics consent to evaluate and treat the above-named minor in my absence. I fully understand that any copays and/or balances are due at services rendered. I will notify office of any insurance changes and/or send minor with current information.

I understand that my signed consent is required to allow treatment of my child/children without personally being present.

_____ _____

Signature of Parent/Legal Guardian Date