Authorization to Treat an Unaccompanied Minor Child

Patient Name:_____ DOB:_____

Parent or Legal Guardian:_____
Print Name

Relationship to Patient:_____

I, _____
Parent or Legal Guardian Name (Print Name)

authorize Dr. Brian Taylor, Joyce Weckl PMHNP, or Fernando Cervantes, PMHNP to treat my child although I may not be present in the office at the time of treatment. I agree to send payment for treatment rendered with my child at the time of the office visit.

Should Dr. Taylor, Joyce Weckl, PMHNP or Fernando Cervantes, PMHNP, need to contact me immediately, please

call_____or_____
.

_____ _____
Signature of Parent or Legal Guardian **Date**