Authorization to Treat Minor Patient in the Absence of Parent or Legal Guardian

I, ________________________________, the parent or legal guardian
(name of parent or legal guardian)

of________________________________, hereby authorize
(name of patient/child)

___________________________________ to accompany my above-named child to
(name of person bringing child to the office)

office visits with Richard W Swails, DPM and to consent to the examination and/or treatment of my child.

This authorization:

☐ is effective for the following date only:_______________

☐ is effective from for visits from____________to______________

☐ is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above-named physician.

Witness Signature____Date____________

Parent/Guardian Signature_____________________________________Date____________

Richard W Swails, DPM
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