1243 Savannah Hwy, Suite B
Charleston, SC 29407
843-556-8110

109 River Landing Drive
Daniel Island, SC 29492
843-849-9582

Authorization to Treat Minor Patient in Absence of Parent/Guardian

I am the parent/legal guardian of the minor child named below. I hereby request, authorize, and consent to the examination and/or treatment of my child by

____ during office visits.

(Provider's name)

This authorization is effective: **(Check one and indicate date(s), if applicable.)**

☐ Only on:

____
Month/day/year

☐ From ______________________ to ______________________
Month/day/year Month/day/year

☐ 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.

Patient's Name

____

Parent/Guardian'ssignature:______________________________

Date:______________________