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AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

Date: ________________________________

I, ____________________________________ hereby authorize ________________________________
(Name of parent or guardian) (Name of treating physician or practitioner)

and/or any associate of his/her, to administer necessary medical care including a pelvic and or gynecologic exam to: ____
(Name of patient/ minor)

I understand that signing this consent allows for medical care to the named minor until the age of 18 with or without my presence.

Signature:____
(Parent or Guardian)

Print Name:____
(Parent or Guardian)

Witness:____
(Signature)