AUTHORIZATION FOR EXAMINATION AND/OR TREATMENT OF A MINOR

I,_____, the parent and/or legal guardian
Printed Name of Parent or Legal Guardian

of_____, _____
Name of Child/Minor (patient) Date of Birth

hereby give consent to the examination and/or treatment of my child/minor during the office visits.

This authorization:

- Is effective only on:_____, 20_____
- Is effective from: _____, 20_____to _____, 20_____
- Is effective until revoked by me in writing

_____ _____ _____
Signature of Parent/Legal Guardian Date Time

_____ _____ _____
The CHI Health Witness Date Time

_____ _____ _____
Second CHI Health Witness – if telephone consent Date Time

10/30/18