Authorization to Treat in the Absence of Parent of Guardian

I authorize the following person(s) to attend the visit with my child and to consent to medical treatment by any provider at Westside Pediatric Clinic, P.C.

1. ____
2. ____
3. ____

The authorization is for my child/children:

1. ____
2. ____
3. ____
4. ____

____

Parent Name **Signature** **Date**