



Authorization to Treat Patient in Absence of Parent/Guardian

I, _____, the parent and or legal guardian of _____, hereby
(name of parent or guardian) (name of patient)

Authorize _____ to accompany the above patient to office visits
(name of person accompanying patient to office)

with _____ and to consent to the examination and/or treatment of
(name of physician/physicians)

of the patient during the office visits.

This authorization:

- Is effective only on _____ (month/day/year).
- Is effective from _____ to _____ (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. I understand that _____ cannot attend his/her appointment without the accompaniment from the person listed above.

Signature of Parent/Guardian Date

****FOR NOTARY USE ONLY****

State of _____ County of _____

On this _____ day of _____ personally appeared before me, the said named _____, to me known and known to me to be the person described in and who executed the foregoing instrument, and that person acknowledges that he (she) executed the same and being duly sworn by me, made the oath that the statements in the foregoing instrument are true.

_____, notary public

My commission expires: _____

Official Seal

No child under 18 years of age, shall be seen without a consent form signed by the custodial parent and acknowledged before a notary public according to the NC Senate Bill 955, Section 1, Chapter 32A of the General Statutes, the completed consent form shall be placed in the Patient's medical chart.