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## **AUTHORIZATION TO PROVIDE MEDICAL TREATMENT**

Patient Name	DOB	
Legal Guardians	Relationship	
$\square$ If other than parent, documentation	n obtained	
	nission to accompany my child (patient abo Associates. My child may be examined an unable to attend.	•
Name	Relationship	
appointment, to include my child's cur	y to provide written documentation, to be rrent medications, as well as an update on e number, if possible, where I can be reach	my child's
Parent Signature	Date	
☐ My child is 16 years or older and maadult.	ay be seen by Dr. Neddenriep or unaccomp	panied by an
 Initials		