Shoreline Orthopaedics

PERMISSION TO TREAT MINOR PATIENT

This form may be used to give consent for another adult to bring your minor child to Shoreline Orthopaedics for follow up treatment. Patient care must have been established with parent or legal guardian present at the first visit.

PATIENT NAME: _____ **DOB:** _____

Any person listed below has permission from_____
(Printed name of parent/legal guardian)
of above named patient, to be present for, and authorize treatment by the providers at Shoreline Orthopaedics, in the event that I myself am unable to be present. I understand that I am still financially liable for any charges/treatment authorized by said person for my child.

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

Signature: _____ **Date:** _____

*****THIS FORM IS VALID FOR SIX (6) MONTHS FROM THE DATE SIGNED*****

Language assistance available
Español | العربية | 繁體中文 | Assyrian | Tiếng Việt | Shqip | 한국어 | বাংলা | Polski | Deutsch

Office Use Only
Expiration Date: _____ Staff Initials: _____