Complete Healthcare for Women of Wellington, LLC
Gynecology

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CONSENT TO TREAT MINOR CHILD

I, _____, parent or legal guardian of
(Please Print)

_____, born the ___ day of _____ ,
(Please Print)

20____ do hereby consent to treatment/medical care in my absence for my minor child.

This authorization is effective from ___ day of _____ , 20____ to

___ day of _____ , 20____

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Signature Witness Name *(Please Print)*

This consent form will be kept on file at the physician's office for treatment when the Parent or Legal Guardian is not present