

Minor Patient Authorization

This form identifies a parent, guardian, or authorized adult who may bring a minor patient to appointments or receive general visit-related information according to office policy and applicable law.

MINOR PATIENT

Minor Patient Name

Date of Birth

PARENT / LEGAL GUARDIAN

Name

Relationship

Phone

Email

AUTHORIZED ADULT(S)

Authorized Adult Name

Relationship

Phone

Expiration Date if Any

Additional authorized adults or limits

AUTHORIZATION

I authorize the adult(s) listed above to accompany the minor patient and participate in appointment logistics as allowed by office policy. I understand additional consent may be required for treatment decisions, records release, or specific services.

Parent / Guardian Signature

Date

Printed Name