Authorization to Treat a Minor Child

Patient Name: _____ DOB:_____

Parent or Legal Guardian: _____
Print Name

Relationship to Patient: _____

I, _____ authorize Dr. Brian Taylor and/or Joyce
Parent or Legal Guardian Name (Print Name)

Weckl, PMHNP to treat my child although I may not be present in the office at the time of treatment. I agree to send payment for treatment rendered with my child at the time of the office visit.

Should Dr. Taylor or Joyce Weckl, PMHNP need to contact me immediately, please call_____or_____
.

_____ _____
Signature of Parent or Legal Guardian **Date**