



## AUTHORIZATION TO TREAT MINOR

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

LEGAL GUARDIAN / PARENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER (PARENT / GUARDIAN): \_\_\_\_\_

I authorize Sooner Urgent Care to provide medical treatment to the patient listed above, as I am not available to attend the appointment(s).

### Check all that apply:

\_\_\_\_\_ The patient is of driving age and will attend appointment(s) by his or her self.

\_\_\_\_\_ The patient will be brought by someone other than myself. I have appointed the following person(s) that have permission to bring the patient to the appointment(s).

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**The person(s) above MUST show Photo ID at the time of check-in**

I understand that by signing this authorization, medical care will be provided to patient without my attendance of appointments. I understand that this authorization expires one year from the date of signature, unless I revoke by written consent.

\_\_\_\_\_  
Signature of legal guardian / parent

\_\_\_\_\_  
Date