Austin Foot and Ankle Specialists Authorization for a Minor

Authorization and Consent for Medical and/or Surgical Treatment of a Minor

I,	, parent/leg	gal guardian of the minor listed below do herel	by give
		gal guardian of the minor listed below do herel receive medical and/or surgical care to include	
	4) T. 10	applies, durable medical equipment, and/or others of Austin Foot and Ankle Specialists.	er
for the minor listed b follow up appointment discussed with any ar	elow. I understand that a nts. I also agree that the nd all of the names listed	ial appointment to discuss at length the treatme another adult may be authorized to bring the m private health information of the said minor w d on this authorization, including the legal guar or the legal authorized official.	inor to
		professional discretion to reschedule the minor sician feel that the parent's involvement facilitate	
	the "Office Policies and	and signed the "Authorization from Patient Leg d Procedures," so that I am fully aware of my	gal
however, this authori	zation does not expire, i	graphics, office policies and medical histories and unless the said minor is of legal age, emancipated for a new accompanying adult is added to the a	tion or
	nt, representing that I have minor listed below.	ave the authority to consent for all medical/surg	gical care
Print Patient Name: _		DOB:	
Print Guardian's Nan	ne:	<u> </u>	
Guardian's Phone Nu	ımber(s):		
Guardian's Signature	:		
9.58	25.5	ring Minor and their relationship to the Minor:	