103 W. Loop 281 Suite 474
Longview, Texas 75605
Phone: (903)230-3311 Fax: (903)230-3312

Treatment Authorization for Minors

We recognize that parents may not always be able to be present during treatment of their young child or teen. This form addresses the situation when your child is accompanied by another adult.

I (parent/guardian): ____

Authorize my child: ____

Date of birth: _____/_____/_____

May be treated and discuss my child's medical needs with the following persons:

Name:	**Relation to patient:**
___________________________	______________________(must have Picture ID at visit)
___________________________	______________________(must have Picture ID at visit)
___________________________	______________________(must have Picture ID at visit)
___________________________	______________________(must have Picture ID at visit)

This authorization is valid for one year unless you notify us otherwise.

___________________________ _____/_____/_____
Parent Signature Today's Date