

Parental Authorization for Care

I, _____ the parent and/or legal guardian of
(name of parent)

_____ hereby authorize
(name of child/children)

_____ to accompany my
(name of person(s) and relationship to child(ren))

above-named child/children to office visits with the providers of Dr. Rice’s office, and

consent to the examination and/or treatment of my child/children during the office

visits. This authorization:

- Is effective only on _____, 20__.
- Is effective from _____, 20__ to, _____ 20__.
- Is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above-named physician.

Date

Signature of Parent/Guardian