AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR IN ABSCENSE OF PARENT/LEGAL GUARDIAN

PATIENT #1:_____ DOB:_____

PATIENT #2:_____ DOB:_____

PATIENT #3:_____ DOB:_____

PATIENT #4:_____ DOB:_____

PATIENT #5:_____ DOB:_____

I hereby authorize Torneria Pediatrics LLC to treat my child I am unavailable. I further authorize the following person(s) to bring my child to Torneria Pediatrics LLC for medical attention if necessary. I understand and have communicated to each person that their personal identification documents must be available for inspection by out staff each time they accompany my child for a medical visit.

_____ RELATIONSHIP_____

_____ RELATIONSHIP_____

_____ RELATIONSHIP_____

SIGNATURE OF PARENT(GUARDIAN)_____

DATE:_____

THIS DOCUMENT EXPIRES IN 12 MONTHS UNLESS THE PARENTS OR LEGAL GUARDIANS OF THE PATIENT CHANGE THE INFORMATION.