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

I hereby authorize Torneria Pediatrics LLC to treat my child I am unavailable.

NAME OF PATIENT #1: _____ DOB: _____

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.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____

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