TRICITY FAMILY MEDICINE & URGENT CARE CLINIC

TELEPHONE PERMISSION
TREATMENT OF MINOR
(Under 18 years of age)

Patient Name: _____

Chart Number: _____ DOB: _____

Parent or Legal Guardian: _____

I, _____, give my permission for Tri-City Family Medicine & Urgent Care Clinic its medical and allied professional staff to treat the above named patient for the following condition(s):

_____

The adult accompanying my child is: _____

Relationship to child: _____

TELEPHONE PERMISION MUST BE WITNESSED BY TWO PEOPLE.

1. _____ Date: _____

2. _____ Date: _____

Revised 8/14