



The Region's Leader In Orthopedic Care

Date: _____

I, _____, parent/legal guardian
(parent/legal guardian name)

of _____, do authorize
(patient name)

_____ to treat the minor for
(treating provider)

his/her _____.
(body part)

Parent/Legal Guardian signature: _____

Printed Name: _____

File the signed copy in Patient Documents ☐ Legal/Medical Request Folder & name **(Date) Minor Consent to Treat**