ALTAMONTE
MEDICAL ASSOCIATES, P.A.

Authorization for treatment of minors ages 16 through 18

Consent to Treat Minor

!

Important

Complete this page only if applicable.

M

Minor Information

Minor Name _____

Date of Birth _____

P

Parent / Guardian Information

Parent / Guardian Name _____

Relationship _____

Primary Phone _____

Alternate Phone _____

A

Authorization

☐ I authorize Altamonte Medical Associates, P.A. to provide medical treatment to the above-named minor.

☐ I authorize emergency treatment when medically necessary.

Parent / Guardian Signature _____ Date _____