Elizabethtown Family Health Center

300 Maytown Road
Elizabethtown, PA 17022
Ph: 717-367-1430 Fax: 717-367-2895

AUTHORIZATION TO TREAT PATIENT IN ABSENCE OF PARENT/GUARDIAN

I, _____, the parent or legal guardian of _____,
(Name of Parent) **(Name of Child)**

hereby authorize Elizabethtown Family Health Center to examine and/or treat my child during office visits.

This Authorization:

____ is effective only on _____.

____ is effective from _____ to _____.

____ is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the Elizabethtown Family Health Center.

Signature of Parent/Guardian _____ Date: _____

Signature of witness _____ Date: _____