Smithson Valley Family Medicine, L.L.P.
"Quality Healthcare in the heart of the Hill Country"

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Canyon Lake, TX 78133
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AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Name of Minor(s)	DOB	Allergies/ Special Conditions

I/ We, being the parent(s) or legal guardian(s) of the above named minors(s), do hereby:

_____Authorize patient to obtain treatment unaccompanied by an adult

_____ Appoint:

Name	Address	Phone #

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minors(s) during the period of my/ our absence, from: _____

****

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

Parent Name: _____ **Date:** _____

_____ _____
Signature of Parent / Guardian **Address**

_____ _____
Signature of Witness **Address**

Revised 09-25-06