

Falls Family Practice
1900 23rd Street
Cuyahoga Falls, OH 44223
Phone 330-923-9585 Fax 330-923-2290

Authorization for Treatment of a Minor

I _____ am the (parent or legal guardian) of _____,
currently a minor whose date of birth is ____/____/____.

I authorize said child's family member/friend, (Name) _____,
(Relationship) _____ to bring my child in for medical treatment at Falls Family
Practice.

I authorize Falls Family Practice to provide medical treatment to my son/daughter, including but not
limited to, diagnostic examinations (including radiological and laboratory testing), TB screening,
verification and/or administering of vaccinations, necessary medical treatment including minor surgical
procedures and mental health counseling.

I understand that should my minor child need more invasive diagnostic or surgical procedures, attempts
will be made to contact me before such care is initiated at 330 _____ or 330 _____.

I further understand that once my child reaches the age of 18, my consent for treatment is no longer
required.

Signature of Parent/Legal Guardian

Date

Printed Name

Relationship