FAANT—Authorization for A Minor

Authorization and Consent for Medical and/or Surgical Treatment of a Minor

I, _____ , parent/legal guardian of the minor listed below do hereby give my authorization and consent for him/her to receive medical and/or surgical care to include, but not limited to, evaluations, procedures, x-rays, supplies, durable medical equipment, and/or other treatment recommended by any of the Doctors of Foot and Ankle Associates of North Texas.

I understand that I must be present at the initial appointment to discuss at length the treatment plan for the minor listed below. I understand that another adult may be authorized to bring the minor to follow up appointments. I also agree that the private health information of the said minor will be discussed with any and all of the names listed on this authorization, including the legal guardians, unless revoked in writing by the said minor or the legal authorized official.

I also understand the physician may use his professional discretion to reschedule the minor's treatment and/or procedures, should the physician feel that the parent's involvement facilitate a more positive outcome.

I also authorize any of the Doctors of Foot and Ankle Associates of North Texas to provide Diagnosis, Practice Status, Weight Lifting Status, Plan of Care and Eligibility of Care, which is also considered Protected Health Information about the patient to the Athletic Department of _____(Highschool) to fax #:_____ .

In addition to this authorization, I have read and signed the "Authorization from Patient Legal Representative," and the "Office Policies and Procedures," so that I am fully aware of my responsibilities and the office policies. I am also aware that the office updates demographics, office policies and medical histories annually; however, this authorization does not expire, unless the said minor is of legal age, emancipation or revoked by the legal guardian in writing.

I am, by this document, representing that I have the authority to consent for all medical/surgical care and/or treatment of the minor listed below.

Print Patient Name:_____ DOB:_____

Print Guardian's Name:_____

Guardian's Phone Number(s):_____

Guardian's Signature: _____

Date: _____

Name and DOB of person(s) authorized to bring Minor and their relationship to the Minor

(i.e. Athletic Trainer, Relative, etc): _____

_____

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