Authorization to Treat Unaccompanied Minor

Full legal name of minor child: _____ DOB: ____/____ /____

ATTENTON: YOUR CHILD MUST BE 16 YEARS or OLDER TO BE SEEN UNACCOMPANIED BY ADULT, *NO EXCPETIONS*

I hereby authorize my minor child (16 years or older), _____to be seen unaccompanied by his/her parent or legal guardian at ADD/ADHD Diagnostic & Treatment Center, PA for examination and /or treatment. I authorize Dr. Chuang and/or other MD associates as may be selected by the attending doctor to examine, evaluate, managed and perform procedures on my minor child and to in all other ways to proceed with their recommended treatment. My signature below attests that I am the parent or legal guardian of the minor named and have the authority to provide this authorization.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Printed Name of Parent/Legal Guardian

Revised 6/29///17 mb