

## CONSENT TO TREAT A MINOR

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

In the absence of a parent or legal guardian I

- DO**
- DO NOT**

give permission for the above named minor child to be seen and treated by the providers of Piedmont Family Practice. This permission shall be in effect until such time as the minor child becomes 18 or I revoke it in writing and the revocation is received by Piedmont Family Practice. I understand that failure to give consent may result in refusal to see my child in the absence of a parent or legal guardian.

\_\_\_\_\_  
Parent / Legal Guardian

\_\_\_\_\_  
Date