Thomas J. Parr, M.D., P.A.

Orthopedic Surgery and Sports Medicine

AUTHORIZATION TO TREAT UNACCOMPANIED MINOR CHILD

*May be faxed to **281-491-0033** or brought with unaccompanied minor patient.*

I hereby authorize either Thomas J.Parr, M.D. to examine and to treat the below named minor patient without my being present.

Patient's Name: _____

Date of Birth: _____

Your relationship to the patient is: ____Parent (custodial)

____Legal Guardian

____Other: _____

This authorization is valid for: ____ today only.

____between ____/____/_____ and ____/____/_____
month day year month day year

____ indefinitely, or until I revoke this authorization in writing.

I may be reached at (_____)_____ if Dr. Parr needs to contact me about my dependent child's orthopedic condition or injury.

_____ _____
Signature Print Your Name

_____
Date