



Dr. Neil P. Superfon, D.O. Dr. William T. Ko, M.D. Dr. John A. Ebner, D.O. Dr. Edward Galicynski, D.O.

**AUTHORIZATION TO TREAT A MINOR  
IN THE ABSENCE OF PARENT / GUARDIAN**

**\*This consent applies to established patients only. New patients under 18 must have a parent or legal guardian present at time of visit.**

Date: \_\_\_\_\_

Name of Minor: \_\_\_\_\_

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

Name of Parent(s) or Guardian(s) \_\_\_\_\_

Person(s) Authorized to Bring Minor: \_\_\_\_\_

Relationship to Minor: \_\_\_\_\_

This authorization is in effect from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Signature of Parent or Guardian

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