Rappahannock Foot & Ankle Specialists
PODIATRISTS - SURGEONS
Restoring Active Fulfilling Lives One Foot At A Time

Authorization to Treat Minor

Name of Minor Patient: _____ DOB: _____

I certify that I am the parent and/or legal guardian of _____
(Name of Child)

- ☐ I authorize _____ to bring my child to office visits with the doctors of Rappahannock Foot & Ankle Specialists
- ☐ I authorize the minor child named above to come alone to office visits with the doctors of Rappahannock Foot & Ankle Specialists
- ☐ I/We, the Parent and/or Legal Guardian will be the only one to bring the child named above to office visits with the doctors of Rappahannock Foot and Ankle Specialists

and I consent to the examination and/or treatment of my child.

This authorization:

- ☐ is effective on _____.
- ☐ is effective from _____ to _____.
- ☐ is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Home Phone Number: _____ Office Phone Number:_____

Cell Phone Number: _____ Other Phone Number: _____

I reserve the right to revoke this authorization at any time by writing to the above-named physician.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

195 Falcon Drive, Fredericksburg, VA 22408 ** Phone: (540) 371-2724 ♦ Fax: (540) 371-5072
450 Garrisonville Road, Ste 115, Stafford, VA 22554 ** Phone: (540) 720-0674 ♦ Fax: (540) 720-8044