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Authorization To Treat In The Absence Of Parent Or Guardian

I authorize the following person(s), **other than the patient's parents**, to be present and to give consent for treatment by Jenny Welham, MD LLC.

Name _____ Relationship _____

Name _____ Relationship _____

This authorization is for the following child/children:

First Name Last Name Date of Birth

First Name Last Name Date of Birth

First Name Last Name Date of Birth

Signature of Parent or Guardian

Address

Phone Date

This authorization is effective until Until further notice