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PATIENT NAME _____ DOB: _____

I, _____, give my permission for _____
(parent/guardian) (name of representative)

to bring my child to appointments, make medical decisions, and authorize medical

treatment for my child in my absence. If there are any questions, I can be contacted at

this number: _____. This authorization is to remain in effect

until I revoke it in writing or until my child turns 18 years of age.

Signature _____ Date _____