FOOT & ANKLE
Associates of Wisconsin

AUTHORIZATION TO TREAT A MINOR PATIENT IN ABSENCE OF PARENT/GUARDIAN

I certify that I am the parent and/or legal guardian of: _____

Date of Birth: _____ Patient MRN (PLACE LABEL) _____

I hereby consent to and authorize Foot and Ankle Associates of WI to provide necessary and recommended care/treatment to said minor child as a patient.

I authorize the following individuals to accompany my child for care/treatment and authorize the sharing of my child's protected health information to the listed person(s):

- I authorize the following individuals to accompany my child for care/treatment:
  Person: _____ Relationship to Patient: _____
  Person: _____ Relationship to Patient: _____
  Person: _____ Relationship to Patient: _____
- I authorize the minor to come in alone and I consent to the examination and/or treatment of my child. (Note: This only applies to minors age 16 and older). If the provider determines there is a need to obtain additional consent or discuss the care/treatment with me, **I can be reached at during the scheduled appointment time:**

  _____
  (Preferred telephone number)

This authorization is valid: (check one)

- On (date of appointment) _____
- Between _____and _____.
- Until revoked by me in writing.

In order to obtain medical care for my child, I do hereby release Foot and Ankle Associates of WI and its related corporate entities, employees and agents from any claim or action based on lack of a consent to treat provided by a parent/legal guardian.

_____ _____
Name of Parent/Legal Guardian (please print) Relationship to Minor

_____ _____ _____
Date Time Signature of Parent/Legal Guardian

James Vavra, D.P.M. Shawn Sanicola, D.P.M.
Amy Galati, D.P.M. Anton Sella, D.P.M. Tyler Veldkamp, D.P.M. Jeremy Philipsen, D.P.M.

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