FAMILY MEDICAL ASSOCIATES
146 Hwy 32-2A
Ashdown, Ar 71822
890-898-5525
Authorization to Treat Minor

_____
Name of Child/Minor

_____
Name of Physician

As the parent/guardian of the above-named child/minor, I hereby give permission to the physician named above to treat the child/minor in the event that a medical emergency arises and I am unable to personally consent to the treatment. I also agree to be responsible to the physician for charges for medical services rendered.

_____ _____
Parent or Guardian's Signature Date