Columbus Foot and Ankle Clinic, PC
Dr. John Hladik, DPM Dr. Ansgar Olsen, DPM
Phone: 812-372-6274

Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of minor patient: _____ Date of Birth: _____

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

☐ I authorize _____ to bring my child to office visits
(Name of person bringing child to office)

with Dr. _____

☐ I authorize the minor child named above to come alone

to office visits with Dr. _____

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: _____