ORTHOPAEDIC SPORTS SPECIALISTS

DATE:_____

PATIENT NAME: _____

PARENT/GUARDIAN NAME:_____

CONTACT PHONE NUMBER:_____

I (PARENT/GUARDIAN) AUTHORIZE ORTHOPAEDIC SPORTS SPECIALISTS PC TO TREAT THE ABOVE NAMED MINOR PATIENT WITHOUT MYSELF BEING PRESENT AT THE TIME OF SERVICE.

PARENT/GUARDIAN'S SIGNATURE:_____

WITNESS SIGNATURE:_____