FLORIDA FOOT AND ANKLE
SPECIALISTS

Authorization to Treat Minor Patient

Name of Minor Patient: _____ **DOB:** _____

I certify that I am the parent and/or legal guardian of the above named patient.

I hereby authorize the medical staff of Florida Foot and Ankle Specialists to render medical and healthcare services and treatments as deemed necessary. This may also include but not be limited to in office procedures, dispensing of DME and imaging studies such as plain film radiographs. I understand that failure to comply with our medical recommendations is against medical advice (AMA).

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Witness Signature **Date**