

# **Willowbend Health & Wellness Associates**

Phyllis Gee, M.D.

Natalie Settele, PA-C

## **Authorization for Treatment of Minors**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient D.O.B. \_\_\_\_\_

I \_\_\_\_\_, parent/legal guardian of the above named patient, give parental consent to Dr. Phyllis Gee and Associates, and her staff to render appropriate care to my child.

I UNDERSTAND THAT THESE RECORDS ARE CONFIDENTIAL AND CANNOT BE DISCLOSED WITHOUT WRITTEN AUTHORIZATION, EXCEPT OTHERWISE AS PROVIDED BY LAW. MY CONSENT MAY BE REVOKED AT ANY TIME. THIS AUTHORIZATION SHALL EXPIRE SIXTY (60) DAYS FROM THE DATE OF MY SIGNATURE.

Name (Print) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_