



Date: \_\_\_\_\_

I hereby give my permission for Family Healthcare Partners  
Physician and/or physician extenders, to treat my child in  
My absence today as I cannot be available for the appointment.

Authorized Individual: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Nature of Illness: \_\_\_\_\_

Name of Parent: \_\_\_\_\_

Please Print Name

Signature of Parent: \_\_\_\_\_