**Pinner Clinic, PA**

 ***A Rich History of Medical Tradition Since 1915***

**Carroll A. Pinner, III, MD Benjamin C. Pinner, MD Lori Turner, APRN Kelsey Rutter, APRN**

**Authorization to Treat Minor Patient in Absence of Parent/Guardian**

*I am the parent/legal guardian of the minor child named below. I hereby request, authorize, and consent to the examination and/or treatment of my child by Dr. Carroll Pinner, Dr. Benjamin Pinner, Edwina Hallman, APRN or Catherine Thomas, APRN during office visits.*

**This Authorization is effective (check one and indicate date(s), if applicable):**

**□**  Only on this date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Effective until revoked by me in writing.

***I understand that I reserve the right to revoke this Authorization at any time in writing to Pinner Clinic.***

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Minor Patient’s Name Date of Birth

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Parent/Guardian’s Printed Name

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Parent/Guardian’s Signature Date