

# CCMH MEDICAL CLINIC

## Authorization to Treat Unaccompanied Minor

PATIENTS NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

I, the undersigned, hereby authorize \_\_\_\_\_ (and whomever he/she may  
Practitioner

Designate as assistant) to administer such treatment as is necessary for the above named patient on (date) \_\_\_\_\_. I hereby certify that I have read and fully understand this authorization. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Date \_\_\_\_\_ Signed \_\_\_\_\_

Or \_\_\_\_\_  
Authorized Person

\_\_\_\_\_  
Relationship to Patient