KELLY S. BRAUER, MD, FACAAI

Consent of Medical Treatment and/or Care of a Minor Child

I, ______________________________ of _________________________________ , do hereby state that I am the
parent or legal guardian City State

guardian of ______________________________ a minor, born on ___________________, who resides with me

Patient

at___________________________________.

Street Address

I hereby give my permission and written consent to

____ to receive medical information and to make medical

Person(s) Accompanying Child

and/or surgical treatment to the above-named child deemed necessary in connection with an injury or illness in my absence from the medical office of Dr. Kelly S. Brauer, M.D.. I hereby give my permission and written consent to Dr. Kelly S. Brauer, M.D. and/or their staff to give medical information to the above-named person accompanying my child and to allow him/her to make decisions on behalf of my child.

This consent is effective from _______________________________until I terminate this consent in writing

Month, Day, Year

and give to Dr. Kelly S. Brauer, M.D.

Signed:____ Date:___________________________

Printed Name:___________________________________

Staff Witness:____________________________________

Printed Name:___________________________________

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