EAU CLAIRE MEDICAL CLINIC SC

A division of Oakleaf Clinics SC

AUTHORIZATION FOR TREATMENT of a MINOR

Patient Name: _____ Date of Birth: ___/___/___

I hereby authorize _____ to bring the above named
(Name/Relationship to Patient)

individual to an OakLeaf Clinics, SC provider for care.

This authorization is in effect until: ___/___/___

Parent/Guardian Name: _____
(Please Print)

Parent/Guardian Signature: _____ Date: ___/___/___