521 N WILMA AVENUE STE A
RIPON, CA 95366

TELEPHONE 209-599-4211
FAX 209-599-7348

www.RiponFP.com

PATIENT NAME___________________________________ DOB: ____________

I, ________________________, give my permission for ________________________
(parent/guardian) (name of representative)
to bring my child to appointments, make medical decisions, and authorize medical treatment for my child in my absence. If there are any questions, I can be contacted at this number: _________________________. This authorization is to remain in effect until I revoke it in writing or until my child turns 18 years of age.

Signature _______________________________________ Date _________________