



The Scholl Center for Communication Disorders

4415 S. Harvard Ave, Ste 125; Tulsa, OK 74135

918-508-7601 Office

918-442-2980 Fax

AUTHORIZATION FOR TREATMENT OF A MINOR

I / We the undersigned parent(s) or legal guardian(s) of the Minor(s) listed below:

_____ Date of Birth _____

(Minor's Name)

_____ Date of Birth _____

(Minor's Name)

_____ Date of Birth _____

(Minor's Name)

Do hereby authorize any medical treatment to said minor under the general, specific or special consent of:

(Name of adult person who is the custodian of minor)

It is understood that this consent given in advance of and specific diagnosis or treatment being required, but it given to encourage those persons who have custody of the minor, and said physician to exercise their best judgment as the requirements of such diagnosis or medical treatment.

I / We accept full financial responsibility for all medical and health care rendered in response to this letter of authorization.

_____ Date _____

(Parent / Legal Guardian)

This consent will expire 12 months from date listed above.

