Salem Clinic
Belong. For life.

PERMISSION TO SEEK TREATMENT - TEMPORARY

_____
Date

_____ _____
Minor Patient's Name *Must fill out separate form for each child.* Account Number

I authorize _____, the minor's _____, to
name of person being given permission to seek treatment relationship to minor (i.e. grandmother)
seek treatment for my child at Salem Clinic P.C.

Salem Clinic, P.C. is further authorized to render to the above patient any medical and /or surgical treatment he/she may require during the following timeframe _____to _____. (Maximum of 180 days)

Patient's known allergies/significant medical history:

_____
_____
_____
_____

Date of last tetanus:_____

Primary Care Physician: _____

_____ _____ _____
Consenting Guardian Signature Printed Name Relationship to Patient (i.e. mother)

****PLEASE PROVIDE PICTURE ID WITH SIGNATURE OF PERSON GRANTING AND BEING GRANTED PERMISSION****