Desert Foot & Ankle
John D. Utley, DPM
8551 W Lake Mead Blvd, Suite 230
Las Vegas, NV 89128
Office: 702-243-7333 Fax: 702-243-4800

Authorization to Treat Minor Patients in the Absence of Parent/Guardian

Date:_____

Name of minor patient: _____ Date of Birth: _____

Allergies to drugs or food: _____

I, _____, parent or legal guardian of

_____ do hereby consent to medical

medical treatment which may include, but not limited to ingrown toe nail procedures, permanent nail removal, wart removal, local anesthesia, x-rays, cast, boot, etc to be determined necessary for the welfare of my child, while said child is under the care of Dr. John D. Utley.

This authorization is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time, in writing, to Dr. Utley's medical office located at 8551 W. Lake Mead Boulevard, Suite 230, Las Vegas, NV 89128.

I understand that I am financially responsible for all treatment Dr. Utley renders to

_____as set forth herein above.
(name of minor patient)

Parent/Guardian: _____
(Please print your name here)

Parent/Guardian signature: _____

Please state your relationship to the minor patient:_____

Mobile phone: _____ Work phone:_____