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AUTHORIZATION TO TREAT MINOR CHILD OR CHILDREN

I authorize Dr. James R. Bond, Jr. and/or his staff, to medically treat my minor child/children.

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

I am giving this authorization due to my absence during the office visit and treatment given by Dr. James R. Bond, Jr. and staff.

This authorization will be good for **one year** from when it is dated below.

Printed Parent/Guardian Name

Relationship

Signature

Date