FAMILY FOCUSED CARE
HEALTH FUSION OF TEXAS

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Permission to Treat a Minor in the Absence of a Parent/Guardian

I, _____, have the legal right to authorize the office of
(Parent or Guardian Name)
Family Focused Care and/or Health Fusion of Texas to provide medical treatment and/or services to my child,_____. I understand that medical advice (including but
(Child's Name & DOB)
not limited to diagnosis, prescription instructions, & appointments) will be relayed to and from my child mentioned above on my behalf.

Parental contact information for questions regarding treatment of the above mentioned child.
This is not a guarantee I will receive a phone from the office of Family Focused Care and/or Health Fusion of Texas.

Parent Name: _____ Phone #: _____

I understand and agree the signatures and dates on this form will not expire without written notice or in case that a minor becomes the age of 18 and that a photocopy of this form is considered valid as the original.

_____ _____
Signature of Parent/Guardian Date