PROFESSIONAL
Foot & Ankle Centers
DAVISON • LAPEER

Mark R. Williams, DPM
Jessica E. Macsuga, DPM
Amanda J. Marshall, DPM

Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of Minor Patient: _____ Date of Birth: _____

I certify that I am the parent and/or legal guardian of _____
(name of child)

❑ I authorize _____ to bring my child to office visits with
(name of person bringing child to office)

❑ Dr. Mark R. Williams ❑ Dr. Jessica E. Macsuga ❑ Dr. Amanda J. Marshall
and I consent to the examination and treatment of my child.

❑ I authorize the minor child named above to come alone to office visits with

❑ Dr. Mark R. Williams ❑ Dr. Jessica E. Macsuga ❑ Dr. Amanda J. Marshall
and I consent to the examination and treatment of my child.

This authorization:

❑ is effective on _____

❑ is effective from _____ to _____

❑ is effective until revoked by me in writing.

Parent/Guardian Contact Information:

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

I reserve the right to revoke this authorization at any time by writing to the above named physician.

Parent/Guardian Signature: _____ Date: _____