Date: _____

791 West Genesee Street
Skaneateles, New York 13152
Tel: 315-685-7544 Fax: 315-685-7549
victorysportsmedicine.com

FOR INTERNAL USE ONLY
ACCT# _____
CSR _____

PERMISSION FOR ANOTHER INDIVIDUAL TO AUTHORIZE TREATMENT

Patient Information

Name of Minor Patient (Last, First, Middle):	**Date of Birth:**

Permission For Another Individual to Authorize Treatment:

1. I am the mother or father of the Minor Patient.

2. I hereby certify that I have the right to consent to Minor Patient's medical treatment and that I am not prohibited from doing so by any agreement or court order.

3. I hereby authorize the person listed below ("Designee") to give consent to examinations, x-rays, MRIs, physical therapy services and other medical services provided to the Minor Patient on the advice of any Victory Orthopedics provider with respect to _____.
   Side of body & body part

Name of Designee:			**Relationship to Minor Patient**	
Address of Designee:	**P.O. Box:**	**City:**	**State:**	**Zip Code:**

4. I hereby certify that there is no court order prohibiting this designation.

Parent Information:

Name of Parent (Last, First, Middle):				
Parent Street Address:	**P.O. Box:**	**City:**	**State:**	**Zip Code:**
Parent Phone Numbers: **Home Phone:**	**Cell Phone:**		**Work Phone:**	

_____ _____

Signature of Parent Date