

EVANGELINE ROXAS-BUTLIG, MD, INC.

PEDIATRIC & TEEN CLINIC

Torrance Clinic:
1727 Crenshaw Blvd.
Torrance, CA 90501
(310) 373-7855

Carson Clinic:
1000 E. Dominguez St, Suite 110
Carson, CA 90746
(310) 715-7755

Fax: (424) 704-2493
www.EvangelineRoxasButligMD.com

CONSENT TO TREATMENT OF MINOR

If the patient is a minor or in any way incapacitated to sign for him/her self, this form is to be completed for each minor and filed in the minor's chart.

This form is an authorization for Dr. Evangeline Roxas-Butlig's office, its doctors, nurses, and members of its staff (hereby referred to as 'clinic') for the following:

Patient Name: _____ Date Of Birth: _____

I, (We), the undersigned, parent(s) or legal guardian(s) of the above named patient, a minor, authorize Dr. Roxas-Butlig's clinic to whom the minor has been entrusted, to act on my (our) behalf to consent to anesthetic, medical, or surgical diagnosis or treatment and care which is deemed advisable by, and is to be rendered under the general supervision of, any duly licensed physician or member of the clinic's staff, anesthetic, medical or surgical diagnosis or treatment thereof.

Additionally, in accordance with California Health and Safety Code, Section 1283, (I) (We) authorize the clinic to release the minor to the physical custody of the undersigned upon completion of the diagnosis and treatment of care.

This authorization shall remain in effect until such time it is revoked in and delivered to the clinic.

Date Signed: _____ Parent or Guardian Name: _____

Parent or Guardian Signature: _____