

Ahwatukee Family Medical Center

13838 S. 46th Place, Suite 320

Phoenix, AZ 85044

AUTHORIZATION TO TREAT A MINOR

I, _____, being the parent or legal guardian of the minor child, _____, do hereby authorize Dr. James Nichols and/or any provider working for or with Dr. James Nichols, to treat the aforementioned minor in case of an emergency.

In the event I am unable to accompany the aforementioned minor to Ahwatukee Family Medical Center, I hereby authorize the following person to act on my behalf:

Name: _____

Address: _____

City: _____ State: _____

Telephone: (_____) _____

Signature: _____ Date: _____