Kat Motlagh's Health Clinics

Katayoun Motlagh, M.D.

AUTHORIZATION TO TREAT MINOR

I _____, hereby give my permission for Kat Motlagh's Health Clinics to treat my minor child _____ without my presence.

Check all that apply:

- Emergency Only
- Routine Appointments Only
- Routine and/or Emergency
- Other (please specify)_____

Signature of Parent or Legal Guardian: _____
Date: _____
Date of Birth of Minor Child: _____
Known Allergies: _____
This authorization will remain in effect until (specify a date or until the child is 18 years old): _____