

Mill Creek Foot and Ankle Clinic  
16708 Bothell-Everett Hwy # 204  
Mill Creek WA 98012  
425-482-6663

## AUTHORITY TO TREAT A MINOR

\_\_\_\_\_  
Patient Name ( Please Print) \_\_\_\_\_  
Date

I hereby authorize Mill Creek Foot and Ankle Clinic to care for the above names patient, and after discussion and approval by me, to administer whatever therapy/treatment the doctor deems necessary or advisable in the diagnosis and treatment of this patient.

Name, Address, Phone number and Date of Birth of **Person responsible** for charges incurred:  
(This is where the statements will be sent)

\_\_\_\_\_  
Name (Please Print) \_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature