HAHN OB-GYN ASSOCIATES

PATIENT OR CHILD'S NAME_____

DATE_____DATE OF BIRTH_____

I, AS PARENT OR GUARDIAN OF THE ABOVE-NAMED MINOR, MAY BE UNAVAILABLE TO AUTHORIZE MEDICAL CARE AND TREATMENT FOR THE ABOVE-NAMED MINOR. THEREFORE, I AUTHORIZE THE PHYSICIANS OF HAHN OB-GYN TO PROVIDE SUCH MEDICAL CARE AND TREATMENT TO THE ABOVE NAMED MINOR, AS REQUIRED.

SIGNATURE:_____

RELATIONSHIP:_____

ADDRESS:_____

_____

PHONE#_____

DATE:_____

WITNESS:_____