Eau Claire Women's and Family Care, OB-GYN Clinic of Eau Claire
Divisions of OakLeaf Clinics SC

AUTHORIZATION FOR TREATMENT of a MINOR

Patient Name: ____ Date of Birth: ___/___/___

I hereby authorize ____ to bring the above named
(Name/Relationship to Patient)

individual to an OakLeaf Clinics, SC provider for care.

This authorization is in effect until: ___/___/___

Parent/Guardian Name: ____
(Please Print)

Parent/Guardian Signature: ____ Date: ___/___/___