



**Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Contact Phone Number:** \_\_\_\_\_

I (Parent/Guardian) authorize Atlantic Physical Therapy Center to treat the above named minor patient without myself being present at the time of service.

**Parent / Guardian's Signature:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_