Durant Family Medicine Clinic
1600 W University Blvd
Durant OK 74701
Phone 580.924.5500
Fax 580.924.1991

www.durantresidency.com

DATE_____/_____/_____

PATIENT_____DATE OF BIRTH_____/_____/_____

I am the parent or legal guardian of the above listed patient and authorize:

_____
to obtain medical care for my child. This person will be required to provide a picture ID at the time of service.

This authorization is valid until revoked.

_____ DATE ____/_____/_____
Parent or Legal Guardian of Patient

☐Mother ☐Father ☐Grandparent ☐Legal Guardian ☐Other_____

Witness:_____Date_____

Revoked by:_____Date_____