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 legal guardian of the patient listed above and authorize Durant Family Medicine Clinic to provide the following medical service to my minor child in my absence:

_____

This authorization is valid for one year from the date of signature.

_____ DATE ____/_____/_____
Legal Guardian of Patient

☐Mother ☐Father ☐Grandparent ☐Other_____

_____
Witness