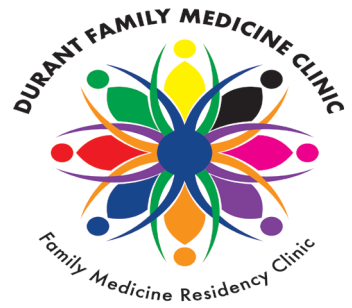


# Durant Family Medicine Clinic

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Durant OK 74701  
Phone 580.924.5500  
Fax 580.924.1991

www.durantresidency.com



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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.

\_\_\_\_\_  
Legal Guardian of Patient DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Mother Father Grandparent Other \_\_\_\_\_

\_\_\_\_\_  
Witness