Colorectal Center of San Diego, Inc.

Dhruvil P. Gandhi, M.D.

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Express Authorization to Examine a Minor

(Patients Under 18 Years of Age)

I, the undersigned, hereby authorize the physician and associated medical staff of Colorectal Center of San Diego, Inc. to examine and/or provide treatment to:

Minor Patient's Name:_____

Minor Patient's Date of Birth:_____

- ☐ I certify that I am the parent or legal guardian of the above-named Minor Patient
- ☐ This form authorizes the above-named Minor Patient to present for medical care and treatment unaccompanied by an adult.
- ☐ This form authorizes the above-named Minor Patient to present for medical care and treatment accompanied by an adult other than their parent or legal guardian.

_____ _____

Parent/Legal Guardian Name (Print) Relationship to Minor

_____ _____

Parent/Legal Guardian Signature Date

CCSD USE ONLY:

STAFF WITNESS TO SIGNATURE:_____ Parent/Legal Guardian Present at First Visit: Y N

NOTES: