

Authorization to Treat

I authorize Independence Urgent Care to provide me or my minor child/ward listed above with any required medical, diagnostic, therapeutic and / or minor surgical procedures/ treatments as may in their professional judgment be necessary/ beneficial for my health or my minor child/ward in my absence.

\_\_\_\_\_  
Authorization Representative Name

\_\_\_\_\_  
Authorized Representative Signature

\_\_\_\_\_  
Relationship to the Patient