



Noel R. Williams, M.D.

I/We, parent(s) or legal guardian, do hereby give permission for medical treatment of:

_____.

Signature: _____

Date: _____

The following person(s) is/are authorized to bring the above named minor to the physician's office for medical treatment.

	<u>Name</u>	<u>Phone Number</u>	<u>Relationship</u>
1.)	_____	_____	_____
2.)	_____	_____	_____
3.)	_____	_____	_____
4.)	_____	_____	_____

This authorization shall remain in effect until notice of revocation is received by Noel R. Williams, M.D. at the above address.

1700 S. Renaissance Blvd. Edmond, OK 73013