



NATHAN HANSEN, DPM  
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BOARD QUALIFIED FOOT & ANKLE  
SURGEON

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## AUTHORITY TO TREAT A MINOR

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

I hereby authorize Hansen Foot and Ankle to care for the above named patient, and after discussion and approval by me, to administer whatever therapy/treatment the doctor deems necessary or advisable in the diagnosis and treatment of this patient.

Name, Address, Phone number and Date of Birth of **Person responsible** for charges incurred: (This is where the statements will be sent)

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

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

\_\_\_\_\_  
Signature