



**AUTHORIZATION FOR
TREATMENT OF MINORS**

David S. Orentreich, MD Catherine A. Orentreich, MD Jodi A. LoGerfo, FNP-BC Sorayah G. Kaschak, NP-BC

Date _____

New York State Law defines individuals under 18 years of age as minors. Accordingly, a parent or guardian of a minor is required to sign a written authorization form before any treatment can be initiated.

I, _____ (parent/guardian) of _____ (patient/minor), hereby request, authorize and give my consent to Dr. David Orentreich, MD, Dr. Catherine Orentreich, MD, Jodi LoGerfo, FNP-BC, Sorayah Kaschak, NP-BC and the staff of Orentreich Medical Group, LLP to examine and treat said minor on an ongoing basis, for :

_____.

Parent/Guardian's printed name: _____

Parent/Guardian's signature: _____

Phone: _____