ADVANCED GASTROENTEROLOGY OF SOUTH FLORIDA, PA
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Board Certified Gastroenterology
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CARE OF A MINOR AUTHORIZATION

Patient's Name _____Date of Birth____/____/___

Parent or Guardian Name _____

I hereby authorize Advanced Gastroenterology of South Florida, PA to provide any necessary medical care and treatment to my minor child mentioned above.

This authorization expires on the minor's eighteen (18^{th}) birthday.

Parent or guardian signature _____

Date _____