Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122

Please bring all completed forms to your appointment

(Office use)

MINOR AUTHORIZATION FORM
(Under 18yrs.)

Patient Name: _____

Date: _____

Procedure: _____

This is to certify that Weill Cornell Imaging has been authorized by me to perform the above mentioned procedure on the above named patient. I am the responsible party for this patient.

Relationship to patient: □ **Parent** □ **Guardian**

Parent/Guardian Information:

Address: _____

Telephone: _____

Date of Birth: _____

Parent/Guardian Signature:

_____ _____ _____ /_____ /20_____
Print First and Last Name Signature Date

Patient Signature if between the ages of 12 -17:

_____ _____ _____ /_____ /20_____
Print First and Last Name Signature Date