

# Orthopedic Knee, Shoulder and Sports Surgery

Michael M. Heckman, M.D., P.A.

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## Authorization for Medical Treatment / Permission from Parent or Legal Guardian

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Date: \_\_\_\_\_

I \_\_\_\_\_, parent or legal guardian to

\_\_\_\_\_ give permission to Dr. Michael M. Heckman to treat my minor child in my absence from his/her office visit. I understand that I am still legally and financially responsible for any decisions and services rendered to my child.

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date

9150 Huebner Rd., Suite #: 330 San Antonio, Texas 78240 \* 210-558-4600 Fax #: 558-4605

# Orthopedic Knee, Shoulder and Sports Surgery

Michael M. Heckman, M.D., P.A.

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## Authorization for Disclosure of Confidential Information & Permission from Parent or Legal Guardian

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Date: \_\_\_\_\_

I \_\_\_\_\_, parent or legal guardian to

\_\_\_\_\_ give permission to \_\_\_\_\_ to represent me in my absence from the office visit. I understand that I am still legally and financially responsible for any decisions and services rendered to my child.

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date

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