Parental Pre-Authorization for Medical Care to Minor Child

To ensure parent authorization this form must be filled out, printed and brought to the office by the parent or legal guardian with identification.

It may be more convenient to have prior authorization for emergency and / or routine medical care delivered directly to minor children without a parent having to be present. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance for emergency and /or routine medical care for your minor child.

I request and authorize **YOUR DOCTORS CARE** and its personnel to deliver emergency and /or routine medical care to my minor child:

Please Print:
Childs Name:_____ **DOB:**_____

In case of emergency please try to contact me (us) at the following telephone number(s):

Parent's name: _____ Phone: _____

Parent's name: _____ Phone: _____

Other (relationship): _____ Phone: _____

I understand this authorization will remain in effect until my child reaches the age of consent or written notification is received withdrawing parental permission for such medical care.

I authorize the following people to bring my child for medical evaluation and treatment.

_____ _____
Name Relationship

_____ _____
Name Relationship

Parents Name: _____ **Relationship _____**

(Signature) _____ **Date: _____**

Note: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.), please explain on the reverse side with your signature, printed name, and phone number at which you can be contacted.