PARENTAL PREAUTHORIZATION FOR MEDICAL CARE TO CHILDREN

For families who are ongoing patients of the Practice, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present during treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

I (we) request and authorize the practice and its personnel to deliver medical care to my (our) child listed below:

Name of Minor: _____ Date of birth: _____

Please try to contact me (us) regarding the healthcare of my (our) child at the following number(s):

1. Parent's name: _____

   Phone (office/home): _____

2. Parent's name: _____

   Phone (office/home): _____

3. Other (relationship): _____

   Phone (office/home): _____

Signature: _____ Date: _____

Print name and relationship: _____

(Only sign this section if below applies)

NOTE: If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.

Signature: _____ Date: _____

Printed name: _____ Phone: _____