

## Parental Pre-Authorization for Medical Care to Children

For families who are ongoing patients of (facility);

---

It may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance:

### AUTHORIZATION

I (we) request and authorize (facility):

---

and its personnel to deliver medical care to my (our) child(ren) and listed below:

PLEASE PRINT

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Please try to contact me (us) regarding health care of my (our) child(ren) at the following phone number(s):

Parent's name:

---

Phone (office/home):

---

Parent's name:

---

Phone (office/home):

---

Other (relationship):

---

Phone (office-home):

---

(Signature) \_\_\_\_\_

Date \_\_\_\_\_

PRINT name and relationship:

---

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

---

---

---

---