HEALTHCARE ASSOCIATES in Medicine, PC

MEDICAL PERMISSION TO TREAT A MINOR

Date: _____

To Whom It May Concern:

Regarding: _____Date of Birth: _____
(Give full Name of Child)

As the parent/guardian of the above named child,

I give permission for:

Name: _____ Relationship: _____

Address: _____

Phone Number: _____

I authorize any medical treatment regarding this child in my absence. This is to include office visits and testing procedures. I hereby assert and claim that I am authorized to give permission to the person identified below as my agent to represent me as my child's guardian exclusively for the purpose to authorize treatment and necessary services to the above named child. I further understand that any instructions that are given to this agent for the care and treatment of this child is my responsibility.
In accordance with the authority vested in me, I hereby authorize the person identified to act as my agent to authorize medical services.

_____ _____
(Print Clearly Parent /Guardian Name) (Date)

_____
(Parent/Guardian Signature)

_____ (_____)_____
(Parent/Guardian Address) (Parent/Guardian Phone Number)

_____

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