PARENTAL ADVANCE CONSENT TO TREAT MINORS

In the event that you are unable to accompany your child to their doctor's appointment, we are required to obtain parental consent prior to treating a child. When parents are not immediately available, this can take time, and delay treatment.

This is to certify that the person/'s listed below has my permission to authorize necessary medical care for my child. This authorization will be in effect until revoked in writing by me. I accept financial responsibility for necessary treatment and services.

Childs Name _____
First *Middle* *Last* *Date of Birth*

Other Children Covered under this authorization _____

_____

Persons (**not Parent**) authorized to seek medical care for the above mentioned child.

_____
Name *Phone Number*

_____
Name *Phone Number*

_____
Name *Phone Number*

_____
Name *Phone Number*

Parent/ Legal Guardians Name *(please print)* _____

Signature _____ Date _____

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