Authorization for Consent to Treat a Minor

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child(ren) in advance. Be advised that protected health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

AUTHORIZATION

I have the legal right to preauthorize this facility to deliver medical treatment to my child(ren). I request and authorize Mt Spokane Pediatrics and it's personnel to deliver medical care to my child(ren) listed below.

Name: ____ DOB: ___________________
Name: ____ DOB: ___________________
Name: ____ DOB: ___________________
Name: ____ DOB: ___________________

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given.

____
____
____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me regarding the health care of my child(ren) at the following telephone number(s). If you are unable for any reason to contact me, you may rely on the proxy decision maker for consent.

Parent's Name: _________________________ Parent's Name: ________________________
Cell Phone: ____________________________ Cell Phone: ___________________________
Work Phone: ____________________________ Work Phone: __________________________

I understand that I may revoke this authorization at any time by notifying Mt Spokane Pediatrics in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

____________________________________ ________________________
Parent or Legal Guardian Date