PEDIATRIC ASSOCIATES OF DURANGO

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Consent Form for Preauthorization to Treat Minors

It may be more convenient to have prior authorization for medical care. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

Authorization:

I request and authorize medical care for my child listed below:

Child Name: _____ Birthdate: _____

You may contact me regarding the care of my child at the following phone number:

Parent Name: _____ Home: _____ Work/Cell: _____

Street Address: _____ City, State, Zip Code: _____

My child will be accompanied by:

Name: _____ Relationship: _____

The abovenamed has my permission to seek medical evaluation treatment for my child. I give permission for the physician to share any relevant health information with the person who is accompanying my child.

Date: _____ From _____ to _____ good for one year.

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

_____

_____

_____

_____ _____

Parent / Legal Guardian Signature Date