Authorization for Health Care of a Minor

Minor Patient

Minor's Name (last, first, middle)

Minor's date of birth (month, day, year)

I, the parent or legal guardian of the minor child listed above, hereby authorize the persons listed below to make health care decisions for my minor child. I understand all copay's must be paid at time of service or there will be an additional billing fee of $25 charged to my account. I also understand whoever brings my child in will be expected to present valid identification and also copies of insurance cards.

Authorization for Health Care

Signature of parent or legal guardian

Date

Print name of parent or legal guardian

Relationship to minor (parent, guardian, other legally authorized person)

Street or P.O. Box

Phone number, including area code

City, State and Zip Code

Authorized Persons

Name

Relationship to minor

Name

Relationship to minor

Name

Relationship to minor

Name

Relationship to minor

This declaration is effective for no longer than one year from the date on which it is signed, or until revoked in writing by the parent or legal guardian.

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