Authorization for Health Care of a Minor

Patient Name ______________________________________ Date of Birth _________________
Last First MI mm/dd/yyyy

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 a 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.

____ ______________________
Signature Date

____ ____
Print Name Relationship to Minor (parent, guardian, or other legally authorized person)

____ ______________________________________
Address: Street or P.O. Box City, State, Zip

____
Phone

AUTHORIZED PERSONS <u>(Other than Parents or Legal Guardians)</u>

Name____ Relationship to Child_____________________________

Name____ Relationship to Child_____________________________

Name____ Relationship to Child_____________________________

Name____ Relationship to Child_____________________________

Name____ Relationship to Child_____________________________

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.