DECATUR PEDIATRIC GROUP, P.A.

Providing medical care for newborns, children, and teens

Temporary Authorization for Medical Treatment of a Minor

I am aware that my child may require medical treatment when I am not able to be present. In my absence, I give my permission to _____ ,
(Individual Name and Relationship to Child)

to authorize medical treatment for my child _____ _____,
(Child's Name) (Date of Birth)

In addition, the treating physician has my permission to refer any emergent care needs for my child to the appropriate hospital or service physician to provide optimal care for the treatment of illness or injury.

I understand that I am responsible for any financial obligation for services rendered to my child.

This authorization begins _____ and ends _____.
(Date) (Date)

_____ _____ _____
Parent/Legal Representative Signature Relationship to Patient Date

_____ _____
Print Parent/Legal Representative Name Contact Phone Number

_____ _____ _____
Witness to Signature Print Name of Witness Date

MEDICAL, PHYSICAL, AND INSURANCE INFORMATION

Please complete:

Allergies_____

Medications_____

Chronic Illness(es) _____

Other Pertinent Medical Information _____

_____

Insurance Carrier: _____ **Member ID/Policy#** _____