AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR IN ABSENCE OF PARENT/LEGAL GUARDIAN

I hereby authorize Pediatric Care of Greater Cleveland at Premier Physician to treat my child when I am unavailable.

NAME OF PATIENT: _____ DOB:_____

I further authorize the following person(s) to bring my child to Pediatric Care of Greater Cleveland at Premier Physician for medical attention if necessary.
I understand and have communicated to each person that their personal identification documents must be available for inspection by our staff each time they accompany my child for a medical visit.

NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____

SIGNATURE OF PARENT/GUARDIAN:_____
DATE: _____

** THIS DOCUMENT EXPIRES IN 12 MONTHS UNLESS THE PARENTS OR LEGAL GUARDIANS OF THE PATIENT CHANGE THE INFORMATION. **