

## Parental Pre-Authorization for Medical Care to Children

For children who are ongoing patients of:

Mitchell County Pediatrics

It is necessary to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

### AUTHORIZATION

I/We request and authorize:

Mitchell County Pediatrics and its personnel to deliver medical care to my child listed below. (Please Print)

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

I/We authorize the following people to bring my child in for treatment:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_

Print Name and Relationship of person completing this form:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_