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Authorization to Obtain Medical Care and Treatment

You may authorize others to obtain medical care and treatment for your child/children by filling out this form.

I, ______________________________ state that I am the legal guardian of:
(Printed Name)

Child's Name: ______________________________ *DOB:* ______________

Child's Name: ______________________________ *DOB:* ______________

Child's Name: ______________________________ *DOB:* ______________

Child's Name: ______________________________ *DOB:* ______________

Child's Name: ______________________________ *DOB:* ______________

I authorize the following persons to obtain and seek medical services and treatment for the above named child/children. I understand that this authorization can be revoked in part or full at any time in writing. I further understand that only myself, another legal guardian of the child/children, the child/children themselves upon reaching the legal age of eighteen years, or a court order can revoke this authorization.

____
(Name) **(Relationship to Patient(s)**

____
(Name) **(Relationship to Patient(s)**

____
(Name) **(Relationship to Patient(s)**

X______________________________ ______/______/______
Signature (Required) **Today's Date**

FOR OFFICE USE ONLY:

I ______________________________ revoke this authorization.
(Printed Name)

Signed X______________________________ Date ______/______/______