

# Midtown Pediatrics

1145 S. Utica Ave, Ste. 403

Tulsa, Ok 74104

P. (918)960-2006

F. (917)900-1813

## Authorization to Treat Minors

I hereby authorize the following people to bring my child to an appointment in my absence. I authorize the physical examination and any x-ray, laboratory test, immunization(s), minor surgical procedure and treatment by any physician or advanced practice registered nurse licensed by the State of Oklahoma and hospital service that may be rendered to said minor under the general, specific or special consent of the temporary custodian of the minor; whether such diagnosis is rendered at the office of the physician or at a hospital licensed by the State of Oklahoma. I authorize the physician to call in any necessary consultants in his/their discretion.

Please list anyone that may bring your child per above other than biological parent or legal guardian.

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

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

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

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

Please list all of your children who you authorize the above individuals to bring to an appointment in your absence.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and said physician is to exercise their best judgment as to the requirements of such diagnosis, medical or surgical procedure.

**\*This consent shall remain in effect until the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, unless sooner revoked in writing, delivered to said physician or said persons entrusted with the custody, care and control of said child.**

Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_