PARENTAL PREAUTHORIZATION FOR MEDICAL CARE TO CHILDREN

For families who are ongoing patients of **Provida Family Medicine**, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present during 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 Provida Family Medicine and its personnel to deliver medical care to my (our) child listed below:

Name: _____ Date of birth: _____

Please to contact me (us) regarding the healthcare of my (our) child at the following number(s):

Parent/Guardian name:_____

Phone (office/home): _____

Parent/Guardian name: _____

Phone (office/home): _____

Print name and relationship of person(s) that may bring the child for medical treatment:

Name_____ Relationship_____

Name_____ Relationship_____

Name _____ Relationship_____

NOTE: *If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below.*

_____

_____

Signature: _____ Date:_____

Printed name: _____

Phone: _____