Dearborn Pediatrics

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MEDICAL CARE AUTHORIZATION FORM (OTHER THAN PARENT)

Please review the following Authorization for Treatment. Complete the information if you would like to grant prior permission for medical treatment for your child/ren in the event of your absence.

Name of Child/ren	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

Please place your initials next to each line as appropriate

I (We), being the parent(s) or guardian(s) entitled to the care, custody and control of the above named minor(s) do hereby authorize **(print name and contact number of the adult who will be caring for the child).**

Name:_____phone number:_____to

_____ Seek appropriate medical treatment or attention on behalf of the child/ren as may be required by the circumstances including the scheduling of appointments.

_____ Sign for medical treatment (including preventative care, sick-child care, immunizations, urgent and emergent care) by Dearborn Pediatrics and its personnel for the above-named child/ren. **Cross out and initial any items you do not consent to.**

_____ Receive financial information

_____ Receive health care information via phone

I agree to keep Dearborn Pediatrics informed of changes in phone numbers, contact info and any custodial changes related to my child/ren listed above.

Parent Signature:_____ Date: _____
Print name:_____Relationship to child: _____

This authorization is in effect for1 year from date listed above unless otherwise specified below: From:_____Until: ___

Revised July 13, 2020