Parental Preauthorization for Medical Care to Children

For families who are ongoing members of the Health*e* Clinic, 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 the Health*e* Clinic and its personnel to deliver medical care to my (our) child listed below:

PLEASE PRINT

Name: ____________________________________

DOB: _____________________________
Please try to contact me (us) regarding the health care of my (our) child at the following number(s):

Parent's name: ____

Phone (office/home): ____

Parent's name: ____

Phone (office/home): ____

Other (relationship): ____

Phone (office/home): ____

Signature: ____

Date: ____

Print name and 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 with your signature, printed name, and a phone number at which you can be contacted.

Signature: ____

Printed name: ____

Phone: ____