

MEDICAL TREATMENT AUTHORIZATION & CONSENT FORM

PATIENT: \_\_\_\_\_

DOB: \_\_\_\_\_

The following portion of this form is designed for situations where minors are not accompanied by a parent/legal guardian but parent/legal guardian's gives consent to designate a specified adult to arrange for medical care of the above-named minor (i.e. grandparent, other relative, daycare provider). This is extremely important, in that, medical care cannot be provided to a minor without approval &/or written consent by the parent/legal guardian. The undersigned hereby authorizes the below designated individual(s) to consent to any medical evaluation, diagnosis, or treatment for the above-named minor, which is deemed advisable by, and to be rendered by, a physician/ provider of U.V.P.

[Parental consent must still be obtained for the administration of any vaccinations]

\_\_\_\_\_  
Designated/Authorized Individual

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Designated/Authorized Individual

\_\_\_\_\_  
Relationship

AUTHORIZED BY:

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

PATIENT:

DOB:

As parent/legal guardian of the above patient I hereby authorize the above indicated minor to attend office visits unaccompanied by a parent/guardian. The undersigned hereby authorizes consent to any medical evaluation, diagnosis or treatment for the above-named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician/provider of U.V.P. in my absence.

Any limitations on services provided or special requests (i.e. communication by phone prior to &/or after provision of services) will be detailed below.

\*Specific Limitations and/or Requests:

[Parental consent must still be obtained for the administration of any vaccinations]

Parent/Legal Guardian Signature

Date