MEDICAL TREATMENT AUTHORIZATION & CONSENT FORM

PATIENT:_____ **D.O.B.**_____

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

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