Integrative Pediatric Health Care

MEDICAL CARE AUTHORIZATION FORM

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 hereby authorize **(print name and contact number of the person(s) 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 IPHC 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 Integrated Pediatric Health Care 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 for 1 year from date listed above unless otherwise specified below:

From: _____ Until: _____

Revised March 20, 2018

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