CAPITAL MEDICAL CLINIC

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Consent Form for Preauthorization to Treat Minors

For families who are ongoing patients of Capital Medical Clinic: it may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to 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 Capital Medical Clinic and its personnel to deliver medical care to my (our) child(ren) listed below:

PLEASE PRINT

Name: _____
DOB: _____
Name: _____
DOB: _____
Name: _____
DOB: _____

Please try to contact me (us) regarding health care of my (our) child(ren) at the following:

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 there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with not- parent, etc.), please explain below with your signature, printed name and phone number at which you can be contacted.