utica park clinic

AUTHORIZATION TO SEEK TREATMENT FOR A MINOR CHILD

I, the undersigned, parent or legal guardian of the minor(s) listed below:

_____ Birth Date: _____
(Minor's Name)

_____ Birth Date: _____
(Minor's Name)

_____ Birth Date: _____
(Minor's Name)

do hereby authorize (name of adult person) _____ permission to consent to any x-ray examination, anesthetic, dental, medical or surgical diagnosis or treatment or hospital care by any physician or dentist licensed by the State of Oklahoma and hospital services that may be rendered to said minor under the general or special supervision and upon the advice of a physician and surgeon licensed under the laws of Oklahoma. This permission includes authority to seek treatment for the minor(s) named above related to regularly scheduled appointments and for acute illness or injury visits with the provider. This permission does not provide authority for decisions to change routinely prescribed medications except by the advice of the physician.

I understand that this permission is given in advance of any specific diagnosis or of any treatment being required, but is given to allow my children to be seen at a time when I/we may be unable to accompany them to be seen by the provider.

This permission shall remain in effect until _____ (date) or until a written revocation is received by the provider.

By signing below, I also represent that I have legal custody or legal guardianship of the minor(s) listed above.

Dated: _____ _____
Parent or Legal Guardian