

Consent Form for Preauthorization to Treat Minors

For families who are ongoing patients of the **Women’s Wellness Center** 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 the **Women’s Wellness Center** 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 phone number(s):

Parent’s name: _____ Phone: _____

Parent’s name: _____ Phone: _____

Other(relationship) _____ Phone: _____

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 non-parent, etc.), please explain in the space below with your signature, printed name, and phone number at which you can be contacted.
