MAIN CENTER
FAMILY MEDICINE
422 N. CENTER ST.
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Authorization for Consent to Medical Care for Minor Children

I: _____ _____
Name Address

_____ _____ _____ _____
City State Zip Phone Number

Am the parent or legal guardian or legal custodian of the following minor child:

_____ _____ _____
Patient Name Date Of Birth Medical Record Number

I hereby authorize: _____ _____
Name Address

_____ _____ _____ _____
City State Zip Phone Number

With whom I am temporarily entrusting the care and custody of my minor child, to consent to any x-ray, examination, anesthetic, medical, surgical diagnosis or treatment and hospital care to be rendered to the minor child under the specific supervision of any physician at Main Street Family Medicine.

This authorization shall be effective from the date signed through _____.
This authorization must not exceed six (6) months from the signature date.

_____ _____
Parent/Guardian Date

_____ _____
Witness Date