PHC
Pediatric Healthcare

Authorization to Obtain Medical Care and Treatment

You may authorize others to obtain medical care and treatment for your child/children by filling out this form.

I, _____ state that I am the legal guardian of;
(Printed Name)

_____
(Child/Children's Name) **(Child/Children's Name)**

_____
(Child/Children's Name) **(Child/Children's Name)**

_____
(Child/Children's Name) **(Child/Children's Name)**

I authorize the following persons to obtain and seek medical services and treatment for the above named child/children.

I understand that this authorization can be revoked in part or full at any time in writing. I further understand that only myself, another legal guardian of the child/children, the child/children themselves upon reaching the legal age of eighteen years, or a court order can revoke this authorization.

_____
(Name) **(Relationship)**

_____
(Name) **(Relationship)**

_____
(Name) **(Relationship)**

_____
(Name) **(Relationship)**

_____
(Name) **(Relationship)**

Signed_____ **Date**_____

I _____ revoke this authorization.
(Printed Name)

Signed _____ Date _____

For Office Use Only:

_____

_____