



AUTHORIZATION AND CONSENT OF PARENT FOR MINOR'S MEDICAL TREATMENT

This form allows another adult to bring your child in for treatment at QuestCare Medical Clinic Facilities. Usually this will be another family member who is caring for your child. The form must be completed and signed by the legal guardian of the child, and allows you to designate who may bring your child in for treatment. Please note that this form allows QuestCare Medical Clinic to discuss protected health information with the person(s) designated in this document.

We request and authorize QuestCare Medical Clinic/QuestCare Medical Clinics and its personnel to deliver medical care to our child(ren) listed below:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

The following people are authorized to bring my child in for treatment.

Name: _____ Relation: _____

Name: _____ Relation: _____

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "none".

Specific health issues important for doctor to know:

Contact Information

If the nature of the medical care is not routine, please try to contact me (us) regarding the healthcare of my (our) children at the following telephone number (s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____

Parent's Name: _____

Daytime Phone: _____

Daytime Phone: _____

Evening Phone: _____

Evening Phone: _____

Cell Phone: _____

Cell Phone: _____

Billing Address: _____

Billing Address: _____

Parent or Legal Guardian Signature

Parent or Legal Guardian Signature

_____ Date

_____ Date

** Please attach a copy of your current insurance card. It would also be beneficial to include any medical information which would be useful to the staff at QuestCare Medical Clinic, such as medical history, medicine allergies, if current on vaccinations, and list current medication.