PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child(ren) in advance.

AUTHORIZATION

I (we) have the legal right to preauthorize Pediatric Associates of Charlottesville to deliver medical treatment to my (our) child(ren). I (we) request and authorize the doctors, nurse practioners and personnel of Pediatric Associates of Charlottesville to deliver medical care to my (our) child(ren) listed below:

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

LIMITATIONS

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

_____
_____
_____

Identify any limitations on the time frame for which this authorization is given. If none, state "**NONE**."

_____
_____
_____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care 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 minor child(ren) for consent.

Parent's Name: _____ Parent's Name: _____
Daytime Phone: _____ Daytime Phone: _____
Evening Phone: _____ Evening Phone: _____
Cell Phone: _____ Cell Phone: _____

IN WITNESS WHEREOF, the undersigned have executed this instrument on:

Date:_____

Signature of parent or legal guardian: _____

Printed name of parent or legal guardian: _____