Facey Medical Group

Temporary Authorization For Consent To Treat A Minor

I am aware that my child may require treatment when I am not able to be present.
In my absence, I give:

1: ______________________________ Relationship: ______________________

2: ______________________________ Relationship: ______________________

3: ______________________________ Relationship: ______________________

My permission to authorize medical treatment for my child, ______________________

- OR -

In my absence, I give permission to a Facey Medical Group provider to administer care and treatment to my child, ______________________

In addition, the provider has my permission to refer my child's emergent care to the appropriate service physician to provide optimal care for the treatment of illness or injury. This authorization is valid until it is revoked in writing.

______________________ ______________________ ______________________

Parent/Legal Representative's **Name** Relationship to Patient Date & Time

______________________ ______________________ ______________________

Parent/Legal Representative's **Signature** Witness to Signature Date & Time

Patient Name:	Medical Record #:
Patient's Date of Birth:	Patient's Phone Number:
Doctor's Name:	Clinic Location & Phone #:
Appointment Date:	
Insurance Coverage:	
Insurance Benefits/Co-Pay:	

SCAN under Consent*