Parental PreAuthorization for Medical Care to Children

Patient Name: _____ **Date of Birth**: _____

For families who are ongoing patients of a New West Physicians facility it may be more convenient to have prior authorization for medical care delivered directly to minors, between the ages of 16-18, without a parent having to be present to treatment. Please review the following authorization for treatment and complete the information if you want to authorize medical treatment in advance.

AUTHORIZATION:
I (we) request and authorize (facility):
_____
and its personnel to deliver medical care to my child. I understand that this authorization is only valid for my child that is a minor between the ages of 16-18. I understand that this authorization is valid unless it is revoked by me in writing and/or the child turns 18 (whichever comes first).
Please try to contact me (us) regarding health care of my (our) child at the following phone number(s):

Parent/Guardian Name: _____ Phone:_____

Parent/Guardian Name:_____ Phone: _____

Signature: _____ Date: _____

Print Name and Relationship: _____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.) please explain in the space below with your signature, printed name, and phone number at which you can be contacted.

_____

_____

_____

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