Painted Rock Family Medicine
Balanced Healthcare for a Balanced Life

Parental PreAuthorization for Medical Care to Children

Patient Name:____________________________ DOB:_______________________________

For families who are ongoing patients of Painted Rock Family Medicine 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 for 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: **Painted Rock Family Medicine** and its personnel to deliver medical care to my chile. 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 telephone 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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