Authorization for Medical Treatment

An *Authorization for Medical Treatment Form* is needed if someone other than a parent or legal guardian is bringing the child to our office. Please fill out this form and have us keep it on file in your child's records/ or send it with the non-parent.

Authorization for Medical Treatment of Child

Pursuant to California Family Code §6910, I/we, the undersigned parent(s) or legal guardian(s) of (name) _____, (date of birth) _____, hereby authorize any or all medical treatments for my/our child at Oskie Pediatrics, to include care marked "YES" below:

☐YES	☐NO	Diagnosis and treatment of illness/problem
☐YES	☐NO	Diagnostic tests (e.g. X-ray, blood draw, etc.) recommended by the doctor
☐YES	☐NO	Preventive care ("well check-up")
☐YES	☐NO	Screening tests as recommended by the doctor
☐YES	☐NO	Immunizations as recommended by the doctor (Vaccine Information Statements will be given to accompanying adult).

I/We authorize the following person/people to seek medical care on behalf of the above named child as indicated:

Name:	Relationship:
Name:	Relationship:

Parent/Guardian Information:

Name (print):		Relationship: ☐ mother ☐ father ☐ legal guardian		
Contact #s:	Work:	Home:	Cell:	Fax:
Signature:				Date:

Parent/Guardian Information:

Name (print):		Relationship: ☐ mother ☐ father ☐ legal guardian		
Contact #s:	Work:	Home:	Cell:	Fax:
Signature:				Date:

Please read each section below and initial indicating your understanding,

Initial here	If you wish this authorization to be effective only for certain dates, cross out the statement above and write effective date(s) here: Through:
Initial here	The person to whom you are delegating authority must be prepared to provide photo ID at every visit to our office(s).
Initial here	You agree that we will bill your insurance plan, if we have current insurance information and can verify coverage, and that you will be responsible for any amounts not covered by insurance, including non-covered tests &/or vaccines.