Traverse Area Pediatric and Adolescent Clinic

AUTHORIZATION FOR TREATMENT

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

I, _____ as parent or legal guardian of child (children) listed above, authorize the following person (people) to bring my child (children) to Traverse Area Pediatric and Adolescent Clinic for the following types of visits. Please include any Step-Parents.

- ❒ Evaluations and Treatment
- ❒ Immunizations
- ❒ Well Visits
- ❒ Lab Tests

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

This Authorization is valid

- ❒ From _____ to _____
- ❒ For one year or until revoked by me.

I may be reached at Phone _____ Cell _____

Parent / Guardian Signature _____

Printed Name of Signee _____