AUTHORIZATION TO PROVIDE MEDICAL CARE

Child's Name:_____
First M.I. Last

Date of Birth:_____ Soc. Sec. #:_____ Sex_____

Address: _____
Street

_____
City State Zip

Parent's Marital Status: **O Married** **O Single** **O Divorced** **O Widowed** **O Guardian**

In case of an emergency and parents cannot be reached please call:

Name:_____ Phone #_____ Relationship_____

In my absence, this is to authorize Park Avenue Medical to provide Medical Care for our child. If in your opinion, another physician needs to be consulted or hospitalization is indicated, we hereby authorize you to do so.

Mother, Father or Legal Guardian _____

Witness _____ Date_____

The following adult persons are authorized to accompany my child and seek medical care from Park Avenue Medical.

Name:_____ Phone # _____ Relationship _____

Name:_____ Phone # _____ Relationship _____

This authorization is in effect until revoked or the date of: _____