York Medical Clinic, P.C.
family medicine

MEDICAL AUTHORIZATION
(TREATMENT OF CHILD)

TO: YORK MEDICAL CLINIC

I, _____, of

_____, make oath and state that I am the lawful guardian/parent of the child named below and there are not Court Orders now in effect that would prohibit or restrict me from exercising the power to consent to the medical treatment of the named child. I am authorizing the Clinic to treat the named child when I am unable to attend the child's appointment and I will call and notify the clinic.

CHILD: _____

SEX: _____

DOB: _____

ADDRESS: _____

When I call and notify the Clinic that I am unable to attend my child's appointment, the Clinic has the right to verify the call prior to the treatment of my child. I understand the Clinic may require approval for each appointment.

PARENT/GUARDIAN: _____

ADDRESS: _____

_____

CELL: _____

HOME TELEPHONE: _____

DATE: _____ **SIGNATURE:** _____

DATE: _____ **SIGNATURE:** _____