Hilltop Pediatrics
300 Highland Ave.Ste.542 | Sherman, TX 75092
Phone: 903.957.0050 | Fax: 903.957.0057

PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR

State of _____

Country of _____

I, _____, parent/guardian of _____ a minor child
(Parent/Guardian name) (Child's name)

born on ____/____/_____ hereby authorize:

_____ _____
Name of authorized individual and relation to patient Name of authorized individual and relation to patient

_____ _____
Name of authorized individual and relation to patient Name of authorized individual and relation to patient

to give consent for the medical treatment of the above named child for any health condition that he/she may encounter, or to bring the child to Hilltop Pediatrics for well check-ups/immunizations. I also authorize Hilltop Pediatrics Staff to give information to the individual named above regarding the diagnosis and plan of treatment, or any information necessary for the care of the above named child, I hereby release Hilltop Pediatrics of any liability regarding release of this information on the above named child.

I hereby authorized my child (ages 16 and 17 only) to receive medical treatment (e.g., well visit, immunization, and/or diagnostic test) without an authorized person accompanying him/her. _____
Initial

- I understand that if someone other than the above listed on this form brings my child(dren) to the medical appointment, my appointment will be rescheduled for another time.
- I understand that even though I have authorized the above named to make treatment decisions regarding the above named child(dren), I will be financially responsible for this family account.

Executed this _____ day of _____, 2009.

_____
Parent/Guardian Name - Print

_____
Parent/Guardian Name – Signature

_____
Witness Signature