tcc | The Children's Clinic

Permission to Treat Authorization Form

Please list the name and date of birth of all children in your family.

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Authorization for Other Caregivers

The person listed below is designated as our agent to give consent (verbal or written) to surgical or medical treatment by any licensed physician or provider at The Children's Clinic for my minor child. Such consent may include but is not limited to, administration of necessary anesthetics, medical treatment, test, X-ray examinations, transfusions, injections, immunizations or drugs and the performing of whatever procedures may be deemed necessary or advisable.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide the authority to consent thereto as our said agent and the above-named child's attending physician, in the exercise of their best judgment, may deem advisable. This authorization shall remain effective unless revoked in writing by the undersigned.

The undersigned hereby authorize (***person other than parent/guardian***):

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

My signature below certifies that all of the above information is true and accurate.

_____ _____

Signature of parent/guardian – type your name for electronic signature Date