(Teens-16,17)

PREAUTHORIZATON TO TREAT MINORS CONSENT FORM

(Teens to be Treated without Parent present)

For families who are ongoing patients of Dr. Bedingfield, Dr. Rosewell, Dr. Silver & Dr. Nourbash.

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child (ren) in advance.

AUTHORIZATON

I (we) have the legal right to preauthorize this facility to deliver medical treatment to my (our) child (ren) listed below. I (we) request and authorize Dr. Bedingfield, Dr. Rosewell, Dr. Silver, Dr. Nourbash & Meredith and personnel to deliver medical care to my (our) child (ren) listed below:

NAME:_____ DOB:_____
NAME:_____ DOB:_____
NAME:_____ DOB:_____
NAME:_____ DOB:_____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "none."

_____

_____

Identify any limitations on the time frame for which this authorization is given. If none, state "none."

_____

_____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s).

Parent's Name _____ Parent's Name _____

Daytime Phone _____ Daytime Phone _____

Evening Phone _____ Evening Phone _____

Cell Phone _____ Cell Phone _____

IN WITNESS WHEREOF, THE UNDERSIGNED HAVE EXECUTED THIS INSTRUMENT AS OF

THE _____ DAY OF _____, 200____.

_____ _____

Parent or Legal Guardian Parent or Legal Guardian