

**CEDAR VALLEY MEDICAL SPECIALISTS
PREAUTHORIZATION TO TREAT MINORS CONSENT FORM**

This consent is to be used for minor procedures and/or already-scheduled procedures in which parents/guardians have already provided consent.

For families who are ongoing patients of _____
(physician or health care facility)

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.

AUTHORIZATION

I (we) have the legal right to preauthorize this facility to deliver medical treatment to my (our) child(ren). I (we) request and authorize _____
(physician or health care facility)

and its personnel to deliver medical care to my (our) child(ren) listed below:

Name: _____	DOB: _____
Name: _____	DOB: _____
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".

CONTACT INFORMATION

If the nature of the medical care is not routine, I understand that every effort will be made to contact me (us) regarding the health care of my (our) child(ren) at the following telephone number(s).

Parent's Name: _____	Parent's Name: _____
Daytime Phone: _____	Daytime Phone: _____
Evening Phone: _____	Evening Phone: _____
Cell Phone: _____	Cell Phone: _____

I understand that this Preauthorization to Treat Minors Consent Form is valid for 1 year from the date of consent.

Parent or Legal Guardian

Date

Parent or Legal Guardian

Date