



Lovenheim Pediatrics

Infants - Children - Adolescents

PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

For families who are ongoing patients of Lovenheim Pediatrics.

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. Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

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 Lovenheim Pediatrics and its 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). If you are unable for any reason to contact me(us), you may rely on the proxy decision maker for consent.

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 _____, 20____.

Parent or Legal Guardian

Parent or Legal Guardian