PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

MEDICAL AUTHORIZATION FOR MINORS

(If needed, one form may be completed for all minors in a single family.)

The following authorization applies to the following minor patient(s) (< 17 years old):

NAME OF CHILD:		DATE OF BIRTH:	
NAME OF CHILD:		DATE OF BIRTH:	
NAME OF CHILD:		DATE OF BIRTH:	
NAME OF CHILD:		DATE OF BIRTH:	
NAME OF CHILD:		DATE OF BIRTH:	

I hereby authorize the following person(s) to authorize evaluation and medical treatment for the patient(s) identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the above patient(s). The duration of this consent is indefinite and continued until revoked in writing.

_____ Relationship to child(ren): _____

_____ Relationship to child(ren): _____

_____ Relationship to child(ren): _____

_____ Relationship to child(ren): _____

_____ Relationship to child(ren): _____

_____ Relationship to child(ren): _____

SIGNATURE OF PATIENT/ PARENT/ LEGAL GUARDIAN DATE

PRINTED NAME

8380 Warren Parkway • Suite 305 • Frisco, Texas 75034

(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com