BAPTIST Primary Care

HEALTH CARE AUTHORIZATION

I,_____ (name of natural or adoptive parent, legal custodian, or legal guardian patient), Hereby give authorization to Baptist Primary Care - Pediatrics to provide medical services and treatment to _____ (name of minor) date of birth: _____ while they are accompanied by the following individuals in my absence:

_____

Name of Authorized Individual and Relationship

_____

Name of Authorized Individual and Relationship

_____

Name of Authorized Individual and Relationship

_____

Name of Authorized Individual and Relationship

☐ _____ Please check and initial here if you give permission for minor to be seen/treated unaccompanied by an adult.

I understand that I may revoke this authorization at any time.

_____

Print name of natural or adoptive parent, legal custodian, or legal guardian patient

_____

Signature Date

_____

Witness Date

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