



TexomaCare – Sherman
2600 North Sam Rayburn Freeway
Sherman, Texas 75090
903.416.3500
Fax – 903.416.3501

PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR

State of: _____

County of: _____

I, _____, parent/guardian of _____ a minor child
(Parent/Guardian Name) (Child's Name)
 born on _____ / _____ / _____ hereby authorize:

 Name of authorized individual and relation to patient

 Name of authorized individual and relation to patient

 Name of authorized individual and relation to patient

 Name of authorized individual and relation to patient

to give consent for the medical treatment of the above named child for any unhealthy condition that he/she may encounter, or to bring the child to TexomaCare for well check-ups. I also authorize the physicians at TexomaCare to give information to the individual named above regarding the diagnosis and plan of treatment, or any information necessary for the care of the above named child, I hereby release TexomaCare of any liability regarding release of this information on the above named child.

I hereby authorized my child (ages 16 and 17 only) to receive medical treatment (e.g., well visit, immunization and/or diagnostic test) without an authorized person accompanying him/her. _____
initial

Executed this _____ day of _____, 2007.

 Parent/Guardian Name - Print

 Parent/Guardian Name – Signature

 Witness Signature

Original is scanned and filed in chart