TexomaCare-Pediatrics and Adolescent Medicine
5012 S. US Hwy 75, Suite 300
Denison, Texas 75020
903.416.6200
Fax – 903.416.6201

PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR

State of: _____

County of: _____

I, _____ (Parent/Guardian Name), parent/guardian of _____ (Child's Name) a minor child

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. I also authorize the physicians and professionals 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 without an authorized person accompanying him/her. _____ initial

Executed this _____ day of _____, 20___.

_____
Parent/Guardian Name - Print

_____
Parent/Guardian Name – Signature

_____
Witness Signature

☐ Original is scanned and filed in chart as well as notated in the EHR system*