Orange Family Physicians
A Division of Anchor Healthcare, PLC
13198 James Madison Hwy, Orange, VA 22960
(540) 672-3010 Fax (540) 672-5713

# PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

*permission from parent for child to bring self to appointment without parent or a proxy

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.

## AUTHORIZATION

I (we) have the legal right to preauthorize Orange Family Physicians to deliver medical treatment to my (our) child(ren). I (we) request and authorize the doctors, nurse practitioners and personnel of Orange Family Physicians to deliver medical care to my (our) child(ren) listed below:

## CHILD(REN):

Name: _____Date of Birth: _____
Name: _____Date of Birth: _____
Name: _____Date of Birth: _____

## 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 minor child(ren) 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 on:
Date: _____
Signature of parent or legal guardian: _____
Printed name of parent or legal guardian: _____

UPDATED 11/29/13