CATHOLIC DIOCESE OF KALAMAZOO

MEDICAL TREATMENT AUTHORIZATION

To Whom It May Concern:
As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor:_____ Relationship: _____

Minor's Date of Birth: _____ Age: _____

Primary Phone _____ Secondary Phone: _____

Reason for which release is intended:_____ _____

Address of Minor: _____ City: _____

Emergency Contact: _____ Relationship to Minor: _____

Phone(s): _____ _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

List allergies, medications, contacts, or other pertinent comments (attach second sheet if necessary):_____

_____ _____

_____ _____

HEALTH INSURANCE DATA:

Company: _____ Policy: _____

Group: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility. By entering into and/or signing this document, the signatory/signatories agree to conduct its/their dealings via electronic means. The signatory agrees that allowing dealings via electronic means will facilitate these dealings. The signatory has the option to opt to sign things in a paper format. **I fully understand and agree to the above terms and sign this form knowingly, willingly and freely.**

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: _____ Signed:_____
(Parent or Guardian)