AUTHORIZATION TO TREAT CHILD(REN) IN ABSENCE OF PARENT/GUARDIAN

I hereby give my permission to the Medical Staff of AdventHealth Ottawa's Physician Practices to treat my child(ren) in my absence.

Child(ren):

Name: ____Birthdate: ________________

Name: ____Birthdate: ________________

Name: ____Birthdate: ________________

Name: ____Birthdate: ________________

Name: ____Birthdate: ________________

The following person(s) has the authority to seek treatment at AdventHealth Ottawa's Physician Practices for my child(ren):

____

I am unable to bring my child(ren) in during this time period for the following reason(s): ____

I understand this authorization is valid for one year unless dates are specified here:

From: ____________________________ To: _______________________________

Further, I have read and agree to adhere to the Financial Policy of AdventHealth Ottawa's Physician Practices in regards to my financial responsibility for this visit(s). I understand that I am the guarantor for my child(ren) healthcare expenses.

Date:_____________________ Signature: _____________________________________

____

Relationship to child(ren)

(Parent or Legal Guardian)

http://www.prch.org/files/KansasMinorsAccess.pdf