CAROLINAEAST PHYSICIANS

Authorization for Medical Care for Minor

I am the parent/guardian of the following minor child:

_____ _____
NAME OF CHILD BIRTH DATE OF CHILD

I hereby authorize the following person(s), upon presentation of appropriate identification, to do the following with regard to obtaining information and/or medical evaluation or treatment for the child at CarolinaEast Physicians and physician practices that are part of CarolinaEast Physicians:

AUTHORIZED PERSON(S)

_____ _____ _____
NAME ADDRESS PHONE

_____ _____ _____
NAME ADDRESS PHONE

Check all that apply:

_____ Physically bring and present the child for medical examinations, immunizations, or other routine medical treatment or services but not give consent for any treatment or services.

_____ Provide consent for medical examinations, immunizations, and other routine medical treatment or services;

_____ Provide consent for administration of anesthesia, X-ray examination, performance of surgical operations, and other procedures by physicians and other medical personnel except the withholding or withdrawal of life-sustaining procedures;

_____ Obtain information about medical care relating to the child from medical providers at the time of such evaluation or treatment;

_____ Obtain copies of medical records and other documents relating to medical care relating to the child.

_____ Pick up prescriptions and prescription refills relating to the child.

This authorization shall be effective from the date I sign it and shall continue in effect unless I rescind it or it expires pursuant to the policies of CarolinaEast Physicians.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

_____

PRINT NAME

_____

WITNESS