



### Preauthorization for Minor Medical Treatment

#### Authorization

I, the Legal Guardian of \_\_\_\_\_, give my consent for  
[Print Child's Name]  
\_\_\_\_\_ to be accompanied by the individuals listed below for office visits  
[Print Child's Name]  
and treatment that only requires general consent. I have already signed the general consent form.

PLEASE PRINT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

You can contact me at the following phone numbers:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

I understand that this consent is in place until revoked by me and/or the expiration of one year.

\_\_\_\_\_  
Legal Guardian Signature                      Relationship of legal guardian to children                      Date