

Traverse Area Pediatric and Adolescent Clinic



AUTHORIZATION FOR TREATMENT

Child's Name _____	Date of Birth _____
Child's Name _____	Date of Birth _____
Child's Name _____	Date of Birth _____
Child's Name _____	Date of Birth _____
Child's Name _____	Date of Birth _____

I, _____ as parent or legal guardian of child (children) listed above, authorize the following person (people) to bring my child (children) to Traverse Area Pediatric and Adolescent Clinic for the following types of visits. Please include any Step-Parents.

- Evaluations and Treatment
- Immunizations
- Well Visits
- Lab Tests

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

This Authorization is valid

- From _____ to _____
- For one year or until revoked by me.

I may be reached at Phone _____ Cell _____

Parent / Guardian Signature _____

Printed Name of Signee _____