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**

Initial 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

The authorized person(s) shall not have personal or other financial responsibility for any medical care to which this authorization relates.

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**