AUTHORIZATION TO TREAT A MINOR

PLEASE BE AWARE THAT BY LAW WE ARE UNABLE TO TREAT A MINOR, UNLESS YOU ARE THE PARENT OR LEGAL GUARDIAN WITH PROOF OF GUARDIANSHIP.

IF YOU ARE NEITHER THE PARENT OR LEGAL GUARDIAN WE MUST HAVE AN AUTHORIZATION LETTER TO TREAT THE CHILD FROM THE PARENTS OR LEGAL GUARDIAN.

I, _____, Authorize Providers at Jupiter Family Healthcare to
(print parent/legal guardian name)
provide medical treatment and diagnosis of my child.

CHILDS NAME_____
(Last name, first name)

Relationship: Mother Father Legal Guardian Other_____

SIGNATURE_____ DATE_____
(parent/legal guardian)

WITNESS_____ DATE_____
(Jupiter Family Healthcare Employee)

ONLY IF APPLICABLE

Verbal Authorization Obtained By_____
(Jupiter Family Healthcare Employee)
On_____At_____.
(date) (time)

Faxed Letter Sent On_____By_____At_____
(date) (persons name) (time)

Received By_____
(Jupiter Family Healthcare Employee)