BIRTH & BEYOND
PEDIATRICS P.C.

AUTHORIZATION FOR TREATMENT FOR A MINOR

Patient Name: _____ Date of Birth: ____ /____ /____

I hereby authorize the following people to bring my child to an appointment in my absence. I authorize the physical examination and any x-ray, laboratory test, immunization(s) and treatment by any physician or advanced practice registered nurse licensed by the State of Oklahoma and hospital service that may be rendered to said minor under the general, specific or special consent of the temporary custodian of the minor; whether such diagnosis is rendered at the office of the physician or at the hospital licensed by the State of Oklahoma. I authorize the physician to call any necessary consultants in his/their discretion.

1. _____ DOB: _____ /_____ /_____ Relationship to child: _____

2. _____ DOB: _____ /_____ /_____ Relationship to child: _____

3. _____ DOB: _____ /_____ /_____ Relationship to child: _____

4. _____ DOB: _____ /_____ /_____ Relationship to child: _____

5. _____ DOB: _____ /_____ /_____ Relationship to child: _____

This consent shall remain effective until _____ unless revoked sooner in writing by parent/guardian and delivered to Birth and Beyond Pediatrics, P.C.

Patient/Guardian Printed name: _____

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

✱ *If this section is not completed the parent/legal guardian must accompany the child to each appointment.*

FOR OFFICE USE ONLY

TELEPHONE CONSENT

1. Consent by telephone may be obtained when prompt treatment is needed or desirable if the patient is a minor.
2. Telephone consents require two witnesses.
3. Telephone consent is for date of service ____ /____ /____ only. If further visits are required, a consent form will need to be completed and on file.

Patient/Guardian giving consent: _____ Phone Number (_____)_____-_____

Name: _____ Relationship to child: _____ Date: _____

Witness Signature: _____ Date: ____ /____ /____

Witness Signature: _____ Date: ____ /____ /___