



**PREAUTHORIZATION TO TREAT MINORS CONSENT FORM**

For families who are ongoing patients of Pediatric Partners, S.C. I (we) appoint \_\_\_\_\_  
Name

\_\_\_\_\_  
Address

who is my (our) child(ren)'s \_\_\_\_\_ as my (our) proxy decision maker for consent to  
(specify nature of proxy's relationship to child(ren))  
medical care for my (our) child(ren).

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child(ren) in advance. Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

**Authorization**

I (we) have the legal right to preauthorize this facility to deliver medical treatment to my (our) child(ren). I (we) request and authorize Pediatric Partners, S.C. and its personnel to deliver medical care to my (our) child(ren) listed below:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Limitations**

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "none".

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Identify any limitations on the time frame for which this authorization is given. If none, state "none".

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Contact Information**

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) child(ren) at the following telephone number(s). If you are unable for any reason to contact me (us) you may rely on the proxy decision maker for consent.

Parent's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
Evening Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

I (we) have read this document and I (we) understand and agree with the requirements of me (us) and our proxy. The information above is true and complete. I hereby authorize Pediatric Partners, S.C. to treat my (our) child(ren). This document will remain a part of the medical record. If I (we) decide not to sign this authorization I (we) understand Pediatric Partners, S.C. can not treat my (our) child(ren) without me (us) being present.

The undersigned have executed this document as of the \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

\_\_\_\_\_  
Parent or Legal Guardian – Print Name

\_\_\_\_\_  
Parent or Legal Guardian – Signature

\_\_\_\_\_  
Parent or Legal Guardian – Print Name

\_\_\_\_\_  
Parent or Legal Guardian – Signature

\_\_\_\_\_  
Proxy Decision Maker – Print Name