PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

Purpose: **This form may be used to allow minors of legal driving age (16 or older) to receive routine care and services at Maryland Primary Care Physicians, LLC medical offices without a parent or proxy present.**

For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors if a parent or legal guardian cannot be present to provide consent. If you would like to have such a preauthorization in place, please review and complete the following form authorizing treatment for your minor child in advance.

AUTHORIZATION:

I have the legal right to preauthorize Maryland Primary Care Physicians, LLC and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, x-rays, lab work (examples include: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, cleaning of minor burns, minor suturing of lacerations, removal of simple cysts, contraceptive care, and incision and drainage of abscesses.)
Please note: Maryland Primary Care Physicians, LLC will not give immunizations, allergy shots or intramuscular/intravenous antibiotics if a parent or proxy is not present to provide consent.

I request and authorize Maryland Primary Care Physicians, LLC and its personnel to deliver routine medical care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:
Name: ____ DOB: ____________________

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given. *(If none, state "none"):*
Parental contact information for questions regarding treatment of the minor child:

Parent's Name:________________________________ Daytime Phone:______________________

Cell Phone:___________________________________ Evening Phone:______________________

Parent's Name:________________________________ Daytime Phone:______________________

Cell Phone:___________________________________ Evening Phone:______________________

I hereby indemnify and hold harmless Maryland Primary Care Physicians, LLC, and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to Maryland Primary Care Physicians, LLC or restricted by time frame as noted above. *Only one parent's signature is required.*

____________________________	__________	____________________________	__________
Signature of Witness	Date	Signature of Parent or Legal Guardian	Date
____________________________	__________	____________________________	__________
Signature of Witness	Date	Signature of Parent or Legal Guardian	Date