Consent form for Preauthorization to Treat Minors

For families who are ongoing patients of Boulder Medical Center, P. C.

It may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize Boulder Medical Center, P. C. and it=s personnel to deliver medical care to my (our) child(ren) listed below:

PLEASE PRINT

Name:_____

DOB:_____

Name:_____

DOB:_____

Name:_____

DOB:_____

Please try to contact me (us) regarding health care of my (our) child(ren) at the following phone number(s):

Parent's name:_____

Phone (office/home/mobile):_____

Parent's name:_____

Phone (office/home/mobile):_____

Other (relationship):_____

Phone (office/home/mobile):_____

(Signature):_____

PRINT name and relationship:

This authorization is effective for the following time periods: _____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.), please explain in the space below with your signature, printed name, and phone number at which you can be contacted.