Temporary Authorization for Medical Treatment

of

_____

Name of Minor

Child Information

Full Legal Name: _____
Date of Birth: _____
Health Insurance Provider: _____
Insurance Policy/Group Number: _____
Social Security Number (Optional): _____

Parent/Legal Guardian Information

Parent/Legal Guardian Name(s): _____
Home Address: _____
Phone Number: _____
Email Address: _____
Alternate Phone: _____

Temporary Caregiver Information

Caregiver Name: _____
Relationship to Child: _____
Address: _____
Phone Number: _____
Email Address: _____

Duration of Authorization

Starting Date: _____

Ending Date: _____

Temporary Guardianship Authorization

I/We, _____, the parent(s)/legal guardian(s) of the above-named minor child, do hereby authorize (Temporary Caregiver) to act on my/our behalf in authorizing medical, dental, surgical care, and hospitalization for the above-named minor during the period of my/our absence.

This authorization is given pursuant to the provisions of applicable state law.

Medical Information

Primary Care Physician: _____
Physician's Phone Number: _____
Health Insurance Provider: _____
Member/Policy Number: _____
Insurance Phone Number: _____

Known Allergies: _____
Current Medications: _____
Medical Conditions: _____

Authorization for Specific Treatments (check all that apply)

_____ Emergency medical care

_____ Routine medical care

_____ Prescription medication administration

_____ Over-the-counter medication administration

_____ Dental care

_____ Mental health services

_____ Immunizations

_____ X-rays and diagnostic imaging

Other: _____

Authorization & Consent for Disclosure of Protected Health Information

I hereby authorize healthcare providers to disclose to the Temporary Caregiver named above any protected health information related to the treatment of my child during the authorized period.

Payment Authorization

I authorize the release of any information necessary to process insurance claims for services rendered to my child during this period. I authorize payment of medical benefits to the healthcare provider for services rendered during this period.

Signatures

Parent Signature: _____ **Date**: _____

Temporary Caregiver Signature: _____ **Date**: _____

Emergency Contacts (Other than Parents/Guardians)

Name: _____
Relationship to Child: _____
Phone Number: _____

Name: _____
Relationship to Child: _____
Phone Number: _____