

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: _____

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