CARY HEALTHCARE ASSOCIATES, PA
301 ASHVILLE AVENUE, SUITE 111 ◊ CARY, NC 27518
919-233-6000 TEL ◊ 919-233-6052 FAX

Medical Authorization Form
(Consent to Treat a Minor, aged 16-18)

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR, AGED 16-18, WHEN UNACCOMPANIED BY PARENT/LEGAL GUARDIAN

I, _____, parent or legal guardian of _____, a minor (aged 16-18), do hereby authorize and consent that he/she may be seen, evaluated and treated by any Medical Doctor, Family Nurse Practitioner, Physician Assistant, Medical Assistant or Nurse at Cary Healthcare Associates.

I understand that any medical treatment provided to _____ will be disclosed to me as the parent/legal guardian upon my request.

Limitations: In the box below please identify any limitations of medical services you, as the parent/legal guardian, do NOT consent the above patient to receive without your verbal consent at the time of the visit (Example: Immunizations, office procedures, exams, labs etc.)

I may revoke this authorization at any time in writing by completing the revocation form which can be provided by Cary Healthcare Associates, PA at my request*

_____ (Printed name of Patient/Date of Birth)

_____ (Parent/Legal Guardian Phone number)

_____ (Parent/Legal Guardian Signature)

_____ (Parent/Legal Guardian Printed Name)

_____ (Witness)

_____ (Date)

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Medical Authorization Form (Consent to Treat a Minor)

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR WHEN PATIENT IS ACCOMPANIED BY AN ADULT OTHER THAN PARENT/LEGAL GUARDIAN

I, _____, parent or legal guardian of _____, a minor, do hereby authorize the following name(s); (example: friend, grandparent, aunt, uncle, neighbor, step parent etc.)

Name	Relationship to patient	Phone number

As my agent(s), I give the above listed permission to consent to any medical evaluation and/or treatment, physical examination, advised immunizations/injections, in office procedures/surgical treatment(s), referrals, diagnosis or care which is deemed advisable by and is to be rendered under, the general or special supervision of a licensed physician, which includes: Medical Doctors (MD), Nurse Practitioners or Physician Assistant.
This authorization includes hospital admission if such is deemed necessary by the physician.
It is understood that this authorization is given to provide authority and power on the part of my absence for the above agent(s) to give specific consent to any and all such evaluation(s)/treatment(s).
This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided.

Limitations: In the box below please identify any limitations of medical services you, as the parent/legal guardian, do NOT consent the above agent(s) to authorize

I may revoke this authorization at any time in writing by completing the revocation form which can be provided by Cary Healthcare Associates, PA at my request*

_____ _____
(Parent/Legal Guardian Signature) (Printed name of Parent/Legal Guardian)

_____ _____
(Witness) (Date)