Monroe Pediatric Associates

A Division of Allied Physicians Group
70 Gilbert Street
Monroe, NY 10950
(845)782-8616

AUTHORIZATION FOR MEDICAL TREATMENT

Date: _____

As the parent/Legal Guardian of _____
(list all applicable children)

Name	Phone
_____	_____
_____	_____
_____	_____
_____	_____

to act in my absence to authorize any medical treatment to include routine exams, immunizations, care of illness, or emergency medical treatment and procedures necessary for the health and well-being of the above mentioned child/children at: Monroe Pediatric Associates, 70 Gilbert Street, Monroe, NY 10950

Please check (if applicable)
___ I also consent for the above named individuals to sign forms necessary for the use and disclosure of Protected Heath Information (PHI) for the above named child/children.

I understand that I will be financially responsible for any care rendered to the above named child/children if accompanied by the/these designated individuals.

Name of Parent/Legal Guardian: _____

Address: _____

Phone: Home _____ Cell _____

Relationship to Patient:_____

Signature of Parent/Legal Guardian: _____

Notary Public:

Person other than parent who has legal guardianship must have a copy of said authorization attached to this form.