Phone: (480) 778-1732 Fax: (480) 778-1709
Email: records@papagopeds.com

Medical Authorization Form

I, _____ hereby grant _____
(Parent/Legal guardian) (Authorized adult/adults)

_____
(Authorized adult/adults)

_____
(Authorized adult/adults)

the authority to obtain medical treatment for the following child/children:

Patient name: _____ Patient D.O.B: _____

Patient name: _____ Patient D.O.B: _____

Patient name: _____ Patient D.O.B: _____

The above authorized adult(s) will have permission to: (check all that apply)

☐ Make medical decisions, during the visit, for my child/children on my behalf.

☐ Leave message and receive calls regarding medical advice for my child/children.

☐ Obtain my child's/children's immunization records and exit notes during the visit.

☐ Make a payment on my child's/children's account during the visit. (Every adult bringing a child will be asked for balance and copay at time of service. Payment options are available to you if you do not want them to be asked, such as leaving a credit card on file or being called when they check it to pay over the phone.)

I understand this authorization will remain in effect until I notify Papago Buttes Pediatric Center to terminate or change this authorization.

_____ _____
(Signature of parent/legal guardian) (Date)