



NORTHWEST ALLIED PHYSICIANS

Parental Pre-Authorization for Minors

I (we) request and authorize the Practice and its personnel to deliver medical care to my (our) child listed below:

Name: _____ Date of Birth: _____

Please try to contact me (us) regarding the health care of my (our) child:

Parent	Parent
Parent's name	Parent's name
Phone	Phone
Signature	Signature
Date	Date
Guardian	Guardian
Name	Name
Relationship	Relationship
Phone	Phone
Signature	Signature
Date	Date

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardians with no-parent, etc.) please explain in the space below with your signature, printed name and phone number at which you can be contacted.

Signature: _____

Printed Name: _____

Phone: _____

Date: _____