Consent Form for Preauthorization to Treat Minors

For families who are ongoing patients of Aurora Womancare:

It may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize Aurora Womancare and its personnel to deliver medical care to my (our) child(ren) listed below:

PLEASE PRINT

Name:_____

Date of Birth:_____

Name:_____

Date of Birth:_____

Please try to contact me (us) regarding health care of my (our) child(ren) at the following phone number(s):

Parent's Name:_____

Phone (office/home)_____

Parent's Name:_____

Phone (office/home)_____

Other (relationship)_____

Phone (office/home)_____

SIGNATURE:_____

DATE:_____

PRINT NAME AND RELATIONSHIP:_____

_____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.) please explain in the space below with YOUR signature, printed name and phone number at which you can be reached.