AUTHORIZATION TO TREAT A MINOR
(Ages 0-18th Birthday)

Patient's Legal Name: First _____ MI: _____ Last: _____

Patient's DOB: _____

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers of Texas Health to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Texas Health of changes or update. I authorize Texas Health to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my child's appointments, insurance, billing information, test results and/or medical care.

Name	Relationship to Patient	Phone

Name	Relationship to Patient	Phone

Parent/Legal Guardian Signature	Parent/Legal Guardian Printed Name	Date	Time

Mobile number

FACILITY NAME MUST BE FILLED IN BLANK BELOW

THPGAUTHMIN

Texas Health®

Patient Name: _____

DOB: _____

MRN: _____