# WESTERN VALLEY FAMILY PRACTICE, P.C.
# REDLANDS AFTER HOURS

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## PARENTAL PREAUTHORIZATION FOR MEDICAL CARE TO CHILDREN

For families who are ongoing patients of Western Valley Family Practice, P.C/Redlands After Hours, 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 request and authorize Western Valley Family Practice, P.C/Redlands After Hours and its personnel to deliver medical care to my child listed below: (please print)**

Name_____ Date of Birth _____

**I authorize my above named child to be:**

***Brought into Western Valley Family Practice for care by:***

Name_____ Relationship _____ Phone_____

Name_____ Relationship _____ Phone_____

***To be seen unaccompanied by parent or legal guardian:***

☐ Yes ☐ No

**This authorization ends:**

☐ on date_____ ☐ one year from date signed

_____ _____
Authorized Signer (please print) Relationship

_____ _____
Date Signature

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 contacted.

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