



HEALTH CARE AUTHORIZATION

I, _____ (name of natural or adoptive parent, legal custodian, or legal guardian patient), Hereby give authorization to Baptist Primary Care - Pediatrics to provide medical services and treatment to _____ (name of minor) date of birth: _____ while they are accompanied by the following individuals in my absence:

Name of Authorized Individual and Relationship

Name of Authorized Individual and Relationship

Name of Authorized Individual and Relationship

Name of Authorized Individual and Relationship

- _____ Please check and initial here if you give permission for minor to be seen/treated unaccompanied by an adult.

I understand that I may revoke this authorization at any time.

Print name of natural or adoptive parent, legal custodian, or legal guardian patient

Signature

Date

Witness

Date