AUTHORIZATION
FOR MEDICAL TREATMENT OF MINORS

In presenting my son/daughter for diagnosis and treatment at CNY Family care

Parent/Guardian Name: _____ for my child_____
☐ Mother ☐ Father ☐ Legal Guardian ☐ Son ☐ Daughter

with a date of birth of _____, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, by authorized members of CNY Family Care staff or their designees, as may in their professional judgement be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my child's condition. I have read this and certify that I understand its contents.

We/I hereby give consent to_____
(Name of Person/ Agency who will bring child to the doctor in your absence)

who will be caring for our (my child) _____?

This consent shall remain in effect from_____until_____, **unless sooner revoked in writing and delivered to said physician** or dentist or said persons entrusted with the care of said minor child.

We/I acknowledge that we are (I am as the parent/guardian) responsible for all reasonable charges in connection with the care and treatment rendered to my child during this period.

Parent/ Guardian Name: _____ Family Physician: **CNY Family Care**

Address: _____ Child's allergies, if any:_____

_____ _____

Telephone no:_____ Special needs, if any: _____

Name of Insurance Carrier: _____ _____

Ins ID number:_____

Parent/ Guardian Signature: _____ Date: _____

Witness Name: _____Witness Signature:_____Date:_____
(*Witnes*s cannot be the person you have designated on this form to take your child to the doctor in your absence)