SWEDISH
MEDICAL GROUP

Authorization for Future Treatment of an Unaccompanied Minor

Duration of Authorization:

- ☐ Upon completion of the treatment identified on the checklist below
- ☐ One year from the date signed below
- ☐ On _____/_____/20___

I understand that I may revoke this authorization in writing at any time prior to the next scheduled appointment.

I, _____ parent/legal guardian of _____,

DOB _____, a minor child, authorize examination and/or treatment of the following checked item(s)

at (facility name) _____ location without my presence:

- ☐ Series of allergy shots
- ☐ Immunization updates
- ☐ Limited, routine physical exam for camp, athletics, school, or other community activity
- ☐ Routine follow up of an injury
- ☐ Cast check and/or removal
- ☐ Suture removal
- ☐ Other routine test or treatment:_____

I understand and agree that I am financially responsible for payment of all expenses related to care provided under this authorization.

I understand the physician will contact me directly for discussion of any unusual or different findings, or if there appears to be a need to change the treatment or plan of care originally intended and authorized.

_____	_____
Printed Name Parent/Guardian	Printed Name Parent/Guardian
_____	_____
Signature Date	Signature Date

Witnessed By: (office staff member)

_____	_____
Printed Name	Signature Date