Lafayette Regional Health Center Rural Health Clinics

Lexington Medical Clinic Higginsville Medical Clinic Odessa Medical Group

Parental Authorization

We realize that there may be times when you as a parent are unable to accompany your child to their office visit. As we require parental authorization to care for your child we ask that you list any family members or other persons who may be informed or participate in your child's care. Appropriate identification in the form of a picture ID will be required from the accompanying adult in the absence of a parent.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

By signing, I acknowledge that the above named parties are allowed to bring my child to appointments, have the power to consent to treatment changes at those appointments, and will be held responsible for any estimated co-payments at the time the service is performed.

_____ _____

Patient Signature **Date**

_____

Witness