



Adult Allergy

Pediatric Allergy

Clinical Immunology

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## Authorization to Consent to Treatment of a Minor

I (we), the parent(s)/guardian(s) of the minor listed below do hereby authorize

\_\_\_\_\_  
(adult into whose care minor is entrusted)

To act in my (our) place to consent to all necessary and appropriate examinations, medical diagnosis or treatment and emergency care which is deemed advisable by and is to be rendered under general or special supervision of any physician or nurse practitioner licensed at Allergy & Asthma Medical Group.

It is understood that this authorization is given in advance of any specific diagnosis or treatment but is given to any physician to exercise the best medical judgment that is deemed advisable and in the best interest of the child.

<u>Child Name</u>	<u>Date of Birth</u>	<u>Allergies</u>
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Our address and phone number is:

\_\_\_\_\_

Medical Insurance Company or Plan: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_

I (we) assume all financial responsibility for the delivery of such care.

\_\_\_\_\_  
(Signature of Parent)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Signature of Parent)

\_\_\_\_\_  
Date

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