PARENT/GUARDIAN AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT OF A MINOR

BARRINGTON
Orthopedic Specialists
Specializing in You

Child/Minor

Full Legal Name: _____
Date of Birth: _____ Age: _____ Gender: _____

Parent(s)/Legal Guardian(s):

Parent/Legal Guardian #1:
Name: _____
Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Pager: _____
Email: _____
Additional Contact Information: _____
_____

Parent/Legal Guardian #2:
Name: _____
Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Pager: _____
Email: _____
Additional Contact Information: _____
_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I, the undersigned, do hereby affirm and represent that I am the parent/legal guardian of the aforementioned minor child. On behalf of the minor child, I hereby consent and authorize Barrington Orthopedic Specialists (hereafter "BOS") to provide reasonable and necessary medical treatment to the minor child, including necessary examinations, X-rays, or other reasonable diagnostic services, and to provide follow-up services as may be required following the examination and treatment for an initial medical condition described as follows:

_____
Description of Condition/Injury

The aforementioned Authorization and Consent shall remain in effect until it is otherwise withdrawn by the parent/legal guardian or until the reasonable and necessary medical treatment for the above described medical condition has ended.

By executing this Consent and Authorization, the parent/legal guardian expressly authorizes BOS to provide subsequent, reasonable, and necessary medical care to the minor child without the parent/legal guardian being present on the dates of subsequent visits where the subsequent treatment is directly related to the above described medical condition.

Signed this _____day of_____, 20 ____. _____
Parent/Legal Guardian