PARENTAL/GUARDIAN AUTHORIZATION
FOR TREATMENT OF MINORS (UNDER AGE OF 18)

I authorize that, in the event of an illness or injury, medical or hospital care is provided to my son/daughter:

_____.
(Print Name)

I further authorize each of the following:

A. I grant permission to the attending physician or Miami VA Healthcare System staff member to employ such diagnostic procedures and medical treatment as deemed necessary.
B. I authorize the Miami VA Healthcare System Employee Health Office or other medical care units to release medical record information to the appropriate health insurance carrier in order to process claims.
C. I understand that I am financially responsible for charges not covered by the Miami VA Healthcare System or insurance and hereby guarantee full payment to the physicians or health care units.

Name of Parent or Guardian _____
(Please Print)

Work Phone No. _____

Home Phone No. _____

Name of Family Physician _____ Phone # _____

Signature of Parent _____Date _____

Signature of Guardian/Custodian _____Date _____

MIAMI VA HEALTHCARE SYSTEM EMPLOYEE HEALTH OFFICE – USE ONLY

FOR TELEPHONE AUTHORIZATION ONLY:

Parent/Guardian Contacted _____ Phone # _____

Witness: _____

Date: _____ Time: _____