

# INDEPENDENCE URGENT CARE

## AUTHORIZATION TO TREAT MINOR

Name of Child/Minor \_\_\_\_\_

As the parent/guardian of the above named child/minor, I hereby give permission to healthcare providers of Independence Urgent Care in Clarkston, Michigan to treat the child/minor in the event that a medical issue arises and I am unable to personally consent to the treatment. I also agree to be responsible to the physician, clinic, lab and all other ancillary service providers for changes incurred relating to medical services rendered.

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Expires one year from date signed- no exceptions.

Instructions: Please fill out form and attach a copy of your driver's license and have the child bring with them the insurance card to their visit.

OR

FAX COMPLETED FORM TO 248.707.8972

Please call to confirm that we have successfully received your document. Thank you

IUC staff member received \_\_\_\_\_ Date \_\_\_\_\_