Authorization for Consent to Medical Care for Minors

Thank you for choosing Ocala Family Medical Center to care for your child. In the future if your child will be attending any office visit, testing, or physical therapy unaccompanied by a parent or guardian, please fill out this form. By signing this form you are allowing your child to receive treatment in our office without being accompanied by a parent or guardian.

Patient's Name: _____

Patient's Date of Birth: _____

Parent/Guardian's Name: _____

Parent/Guardian's Phone #: _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone #: _____

Insurance Company: _____

Contract #: _____ Group: _____

Policy Holder's Name: _____

I agree that the above information is correct to my knowledge. By signing this form I am allowing Ocala Family Medical Center to treat my child without a parent or guardian present.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness Signature: _____ Date: _____