BOULDER ENDOCRINOLOGY, PLLC

CONSENT FORM FOR PREAUTHORIZATION TO TREAT MINORS

For families who are ongoing patients of Boulder Endocrinology Associates, PLLC, it may be more convenient to have prior authorization for medical care delivered directly to minors without having a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

I (we) authorize Boulder Endocrinology, PLLC, and its personnel to deliver medical care to my (our) children listed below:

PLEASE PRINT

Minor's name: _____

DOB: _____

Minor's name: _____

DOB: _____

Please try to contact me (us) regarding health care of my (our) children at the following phone numbers:

Parent's name: _____

Phone (home/cell/office): _____

Parent's name: _____

Phone (home/cell/office): _____

Other (relationship): _____

Phone (home/cell/office): _____

Signature: _____ Date: _____

Print name: _____ Relationship: _____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.), please explain in the space below with your signature, printed name, and phone number at which you can be contacted.

Signature: _____ Date: _____

Print name: _____ Phone: _____