Medical Authorization to Alternate Caregiver

Child's Name: _____ Chart #: _____

Date of Birth: _____

Parent / Legal Guardian's Name: _____

Name of Authorized Adult: _____

Permission for medical treatment:

In my absence, _____ *(name of parent or legal guardian)* I authorize my child's caregiver, _____ *(name of authorized adult)* to seek services for my child *(listed above)* from Capital Area Orthopedic Associates for treatment, including hospitalization, local anesthesia, office surgery (i.e. incision and drainage), radiology testing, laboratory testing, injections of medication, casting and DME.

This authorization is effective from: _____ to _____. However, I understand that I can withdraw authorization at any time, with written notice.

Parent or Legal Guardian's Signature: _____

Date: _____