



PARENTAL AUTHORIZATION TO TREAT

Parental Authorization is required to treat any minor under the age of 18 years.

I, \_\_\_\_\_, authorize Total Access Urgent Care to administer any medical care, including diagnostic procedures, deemed necessary by the physician for my child, \_\_\_\_\_.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. In addition, I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered during this period.

In case of emergency, I may be reached at \_\_\_\_\_.

Parent Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_