Scarano & Taylor Pediatrics

Joseph Scarano, MD FAAP A. Florentina Taylor, MD FAAP

AUTHORIZATION FOR 16-17 YEAR OLD MINOR TO RECEIVE MEDICAL TREATMENT WITHOUT PARENT/LEGAL GUARDIAN

This form authorizes persons sixteen and seventeen years of age to receive medical treatment at this office without the presence of a parent/legal guardian.

This document authorizes our staff to provide all usual well and sick child care, including vaccination and minor procedures, unless you note any limitations below.

The provision of medical care in the absence of a parent/legal guardian is a privilege that we extend to families for their convenience. *We may revoke or suspend this privilege at any time at our discretion.*

PLEASE PROVIDE ALL REQUESTED INFORMATION

I authorize

_____

[NAME OF PATIENT]

to receive medical care at the office of Scarano & Taylor Pediatrics in the absence of a parent/legal guardian.

Please list known **ALLERGIES**:_____ **□NONE**

Please list any **LIMITATIONS** to this medical release:

_____ **□NONE**

Signature of Parent/Legal Guardian:_____

Home Phone:_____ **Work Phone**:_____

Date:_____

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