TREATMENT AUTHORIZATION FOR MINORS

I, the undersigned parent/guardian of (patient's full name) ______________________________________
grant permission and authorize medical care and treatment for the above named individual with Women's Care of Wisconsin.

This authorization shall be valid until I choose to revoke it in writing. I do hereby indemnify and hold harmless the health care provider(s), Women's Care of Wisconsin, or other persons who act in reliance upon this authorization and medical information.

I understand that as the patient's parent/guardian it is my responsibility to keep the medical information current for the above named patient. The health care provider at Women's Care of Wisconsin will be relying on the information provided, it is imperative that the information be accurate.

Parent/Guardian Signature: ____

Relationship to Patient: ____

Date: ______________________________