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AMD Urgent care Authorization to Treat Minor

Name of Child/Minor

AMD Urgent Care

Name of Clinic

As the parent/guardian of the above-names child/minor, I hereby give my permission to health providers of the clinic named above to treat the child/minor in the event that a medical issue arises. I also agree to be responsible to the physician, clinic, lab and the other ancillary service providers for the charges incurred relating to medical service rendered.

Parent or Guardians Signature

Date

Instructions: Please fill out the above form and have the child bring with them to their visit

Or

FAX COMPLETED FORM TO 810.564.7999