7070 Miller Rd. Suite A
Swartz Creek, MI 48473
Office: 810.564.7995, Opt. 4
Fax: 810.221.1340
Email: amdurgentcare@gmail.com
Website: www.amdurgentcare.com

AMD Primary Care Authorization to Treat Minor

_____

Name of Child/Minor

AMD Primary 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 810.221-1340