MEDICAL TREATMENT RELEASE FORM

(Required by the Archdiocese of Detroit)

To Whom It May Concern,

As parent/guardian, I do hereby authorize the treatment of a qualified licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. The authority is granted only after a reasonable effort has been made to reach me.

1. Name of Minor:_____ Relationship to you:_____
Reason for release is intended:_____
Address of Minor:_____ City:_____
Emergency Phone(s):_____
Family Physician:_____Phone:_____
Physician Address:_____ City:_____
List of allergies, medication, contract or other pertinent comments:_____
_____

2. Name of Minor:_____ Relationship to you:_____
Reason for release is intended:_____
Address of Minor:_____ City:_____
Emergency Phone(s):_____
Family Physician:_____ Phone:_____
Physician Address:_____ City:_____
List of allergies, medication, contract or other pertinent comments:_____
_____

3. Name of Minor:_____ Relationship to you:_____
Reason for release is intended:_____
Address of Minor:_____ City:_____
Emergency Phone(s):_____
Family Physician:_____ Phone:_____
Physician Address:_____ City:_____
List of allergies, medication, contract or other pertinent comments:_____
_____

Health Insurance Data:

Company:_____ Policy:_____

Group:_____ Contract;_____

I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date:_____ Signed:_____

(Parent or Guardian)