



700 KATLIAN STREET SITKA, AK 99835 (907) 747-5861

Sitka Medical Center
Count on our family to take care of yours.

**PARENT/GUARDIAN PRE-AUTHORIZATION TO PROVIDE
MEDICAL CARE TO AN UNACCOMPANIED PATIENT**

In order to provide the best medical care for your child, we recognize there are times when you are unable to attend your child's appointment. For your convenience, we provide this authorization to allow medical care for your child in your absence. Please review the information below. Initial the section(s) that are applicable, sign and return this form to our office **PRIOR TO YOUR CHILD'S APPOINTMENT** should you wish to authorize treatment without a parent/guardian being present.

CONSENT TO PERMIT CERTAIN INDIVIDUALS TO ACCOMPANY CHILD FOR TREATMENT:

I, _____, hereby authorize the following individual(s) to accompany my child to Sitka Medical Center for the provision of medical services, and to view or discuss my child's Protected Health Information (PHI). This form has no expiration date and any changes must be made in writing.
Name(s) of step-parent, grandparent, nanny/au pair/babysitter/other and relationship to child.

These individuals are able to authorize general medical treatment and additional diagnostic and medical procedures including but not limited to (check authorized categories): Immunizations Lab Orders

ONLY PARENT/GUARDIAN MAY ACCOMPANY CHILD FOR TREATMENT TO SITKA MEDICAL CENTER:

I, _____, **DO NOT** authorize anyone other than the child's father, mother, and/or guardian to accompany my child to Sitka Medical Center for the provision of medical services,

CONSENT TO TREAT UNACCOMPANIED MINOR AT SITKA MEDICAL CENTER:

I, _____, request and authorize Sitka Medical Center and its personnel to deliver medical care to my MINOR CHILD listed below, even if he or she is unaccompanied.
Minor Name/Date of Birth:

I acknowledge that I continue to be responsible for all reasonable charges incurred for my child, and that no guarantees have been made to me regarding the effect or outcome of treatment provided hereunder.

Please print all information for parent or legal guardian identification:

Last name, First name Date of Birth

Last name, First name Date of Birth

I/we may be reached at the following telephone numbers during my child(ren)'s appointment.

Parent/Guardian/s Name Best number to be reached Alternate number

Parent/Guardian/s Name Best number to be reached Alternate number

PRINT NAME RELATIONSHIP SIGNATURE DATE

Please advise if there are parent/custodial relationships our office needs to be aware of. Thank you.

This authorization is valid until _____ unless otherwise revoked in writing.