Parental Preauthorization
Medical Care for Children

Parents who are ongoing patients of Lutheran Medical Group may find it convenient to authorize medical care for minors in their family in advance. Completion of this form allows LMG to deliver medical care to minors without a parent present. Parents who wish to authorize treatment in advance should complete and submit this form.

Authorization Date ______________________________

I (we) request and authorize Lutheran Medical Group and its personnel to deliver medical care to my (our) child named below:

Please print

Name of child: ______________________________

Date of birth: ______________________________

Please try to contact me (us) regarding the care of my (our) child at the following number(s):

1. Paren'ts name: ______________________________

Phone (office/home): ______________________________

2. Parent's name: ______________________________

Phone (office/home): ______________________________

3. Other (relationship): ______________________________

Phone (office/home): ______________________________

NOTE: If a special parental or custodial relationship (such as single-parent custody, legal custody/guardians with no parent, etc.) exists, please explain the conditions of this agreement.

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Signature ______________________________

Printed name: ______________________________

Phone: ______________________________