TEMPORARY AUTHORIZATION TO CONSENT TO TREATMENT

Children's MINNESOTA | Partners in Pediatrics

Effective Date(s): _____

Patient's Name: _____ Date of Birth: _____

Parent's: _____

Phone number(s) where parents can be reached: _____

Person(s) caring for my child: _____

Child's Physician: Partners in Pediatrics Usual Provider: _____

My child is usually seen at the following office:

❑ **BROOKLYN PARK OFFICE**
8500 Edinbrook Parkway
Brooklyn Park, MN 55443
Phone (763) 425-1211
Fax (612) 874-2907

❑ **MAPLE GROVE OFFICE**
12720 Bass Lake Road
Maple Grove, MN 55369
Phone (763) 559-2861
Fax (612) 874-2902

❑ **PLYMOUTH OFFICE**
2855 Campus Drive #350
Plymouth, MN 55441
Phone (763) 520-1200
Fax (612) 874-2908

❑ **ROGERS OFFICE**
13980 Northdale Boulevard
Rogers, MN 55374
Phone (763) 428-1920
Fax (612) 874-2916

❑ **ST. LOUIS PARK OFFICE**
3910 Excelsior Boulevard
St. Louis Park, MN 55416
Phone (612) 827-4055
Fax (612) 874-2909

Medical Insurance Company: _____

Group/Policy #: _____ ID#: _____

Child's Medical History:

Chronic conditions: _____

Medications that child takes on a regular basis: _____

_____

Allergies: _____

Dietary or other restrictions: _____

I/We give permission for the person(s) listed above to make medical decisions for my/our child in my/our absence. I/We can be reached at the number above in case of an emergency.

I/We understand that this consent will last for the dates indicated above or one year if no dates are indicated unless I change my mind and withdraw the consent sooner in writing. If I withdraw consent, it will not affect actions already taken by Partners in Pediatrics.

Parent Signature: _____ Date: _____

Parent Signature:_____ Date: _____