

If the minor is 16 or 17 years of age, he/she can be seen by themselves with your written consent.

Minor's Name: \_\_\_\_\_\_ DOB: \_\_\_\_\_

I (parent/legal guardian) \_\_\_\_\_\_

authorize Western Michigan Pediatrics to deliver care to my minor child. I am

aware that I am responsible for payment of the patient portion such as copays,

deductibles and co-insurance.

Permission is given for the following types of visits:

- □ Well visits
- □ Recommended Immunizations
- □ Lab tests or x-rays

This Authorization is valid:

For this date only	
□ Indefinitely, or until revoked by me.	-

I may be reached at the following phone number:\_\_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

Signed:			