western michigan PEDIATRICS

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:

- ☐ Evaluation and treatment
- ☐ 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: _____ Date:_____