Bay Area
Family Physicians, P.C.
34301 23 Mile Road, Suite 100 • New Baltimore, MI 48047 • 586/ 725-1770 FAX: 586/ 725-4080

Authorization for Consent to Medical Care for Minors

Thank you for choosing Bay Area Family Physicians. If your child will be coming to an appointment unaccompanied by a parent/guardian, please fill out this form prior to the date of service. By signing this form, you are agreeing to allow your child to be seen and treated by a Bay Area physician.

Patient's Name:_____

Patient's Date of Birth:_____

Patient's Appt Date/Time:_____
**Please note that this form is only accepted for the appointment date and time named above.

Patient is being seen by:_____

Parent/Guardian's Name:_____

Parent/Guardian's Phone #:_____

Name of adult accompanying minor:_____

Relationship to minor:_____

Emergency Contact Name:_____

Emergency Contact Relationship:_____

Emergency Contact Phone #:_____

Insurance Company:_____

Policy Holder's Name:_____

I agree that the above information is correct to my knowledge. By signing this form, I am allowing the physicians at Bay Area Family Physicians to treat my child without a parent/guardian present. If another adult is accompanying my child (as named above), I authorize this individual to make medical decisions for my child on my behalf in my absence.

Parent/Guardian Signature:_____

Date:_____