JULIA BARRIGA MD PA
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AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS 8-26-19
by other than the Parent or Guardian

Patient's Full Name: ______________________________________ Date of Birth:____________

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Patient's Full Name:______________________________________ Date of Birth:____________

Individual (s) authorized to bring children (listed above) for treatment (including Mom and Dad)
Every Person bringing children MUST PRESENT A PICTURE ID AT EVERY VISIT
(Individual must be at least 18 years old)

Name:_____________________________ Phone________________ Relationship:__________

Name:_____________________________ Phone________________ Relationship:__________

Name:_____________________________ Phone________________ Relationship:__________

Name:_____________________________ Phone________________ Relationship:__________

Name:_____________________________ Phone________________ Relationship:__________

Signature(s)

I as the parent/ legal guardian authorize the Individual(s) (listed above) to bring my child/children (listed above) to Julia Barriga, M.D.,P.A. to receive medical services. I am also aware that this Individual should be responsible for any payments due at the time of service or previous balances.

Please make sure the designated individual knows about the current condition of the patient and that he/she can transfer all the information provided on the visit to the parent or guardian.

PARENT / GUARDIAN NAME____ LEGAL RELATIONSHIP TO PATIENT_______

Phone Number to reach you if needed during the visit :_________________________________

PARENT / GUARDIAN SIGNATURE ____ DATE ____________________