MR # DOB

NAME

DATE

BASSETT HEALTHCARE NETWORK
☐ **BASSETT MEDICAL CENTER**
Cooperstown, NY 13326-1394
☐ **LITTLE FALLS HOSPITAL**
Little Falls, NY 13365
☐ **TRI TOWN REGIONAL HOSPITAL**
Sidney, NY 13838

PREAUTHORIZATION TO TREAT MINORS CONSENT

H-6027 12/03;5/04;4/08 (d:\forms\hosp\.ofm)

Health Center: _____

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child in advance.

AUTHORIZATION

I (we) have the legal right to preauthorize this facility to deliver medical treatment to my (our) child. I (we) request and authorize this facility and its personnel to deliver medical care to my (our) child listed below:

Child's Name: _____ DOB: _____

LIMITATIONS

Specify the types of medical services for which this authorization is given.

_____

_____

_____

Specify the time frame for which this authorization is given. (Time frame not to exceed three months)

_____

_____

_____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) child at the following telephone number(s).

Parent's Name:_____ Parent's Name:_____

Daytime Phone:_____ Daytime Phone:_____

Evening Phone:_____ Evening Phone:_____

Cell Phone:_____ Cell Phone:_____

_____ _____

Parent or Legal Guardian Parent or Legal Guardian

CONSENTS