TPG
Texoma Physicians Group

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Sherman, TX 75090
Phone: 903-202-2900
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Parental Authorization for Treatment of a Minor

State of: _____

County of: _____

I, _____, parent/guardian of _____, a
Parent/Guardian Name Patient's Name

minor child born on _____/_____/_____ hereby authorize:

_____ _____
Name of authorized individual/relation Name of authorized individual/relation

_____ _____
Name of authorized individual/relation Name of authorized individual/relation

To give consent for the medical treatment of the above-named child for any condition that he/she may encounter and to give consent for all well child checkups, including vaccinations, at Texoma Physicians Group, PLLC. I also authorize the providers within the group to give information to the individual(s) named above regarding the diagnosis, plan of treatment and any information necessary for the care of the above-named child. I hereby release Texoma Physicians Group, PLLC of any liability regarding the release of this information on the above-named child.

Optional: I hereby authorize my child (ages 16 years and up only) to receive medical treatment without an authorized person accompanying him/her. _____
Initial

Executed this _____ day of _____, 20_____.

_____
PRINT – Parent/Guardian Name

_____
SIGNATURE – Parent/Guardian Name