Capital Area Pediatrics
3937 Patient Care Drive, Suite 101
Lansing, MI 48911

Authorization of Treatment of Minor
By Non parental Adult

Name of Patient_____

Date of Birth _____

I _____give permission for the person or people listed below to authorize treatment
Parent/Guardian's Name
for _____. I understand that by giving this authorization, I am giving my permission
Name of Child
for Capital Area Pediatric staff to release personal health information about my child to named person.

This authorization begins on the day that this paper is signed.
☐ The authorization is for today's visit only.
☐ The authorization ends _____
☐ The authorization ends one year from the dated signed

Name of Authorized Person	Relationship to child
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Parent/Guardian _____

Date _____