CARE AUTHORIZATION

Name of Child:_____Date of Birth:_____

I, _____, as parent or legal guardian, give permission to

_____Relation:_____

to obtain medical information and/or make medical decisions for the above named child.

I can be contacted at the following number (___) ____-____ (work, cell, home) or (___) ____-____ (work, cell, home).

Please initial one of the following:

I understand that this authorization is good for one year from the signed date._____

I understand that this authorization is good until revoked by me._____

Insurance Information:

Primary Insurance:_____Policy Holder's Name:_____

Group #:_____ID #:_____

Secondary Insurance:_____Policy Holder's Name:_____

Group #:_____ID #:_____

Parent/Guardian Signature:_____Date:_____

Parent/Guardian Name:_____Relation:_____

1510 Division St., Suite 280, Oregon City, Oregon 97045. Phone 503 950 3400. Fax 503 905 3399
200 S Hazel Dell Way, Suite 202, Canby, Oregon 97013. Phone 503 266 8500. Fax 266 8585