



MEDICAL RELEASE FOR MINOR CHILD

I, _____, the parent or legal guardian of, _____ a minor child, hereby authorize any medical or surgical treatment that may be necessary in an emergency, and in my absence, for the well being of the above mentioned minor. I agree to hold the physician and/or hospital treating the above mentioned minor, harmless.

Bill insurance Bill will be paid at time of service.

PATIENT/PARENT OR LEGALLY AUTHORIZED INDIVIDUAL'S SIGNATURE

DATE AND TIME

PRINTED NAME

RELATIONSHIP