MICHAEL W. JOHNSTON, M.D.

7 Windsweep Court
Phenix City, Alabama 36870
Phone (334) 297-5555
Fax (334) 297-5525

Child Name: _____ Date of Birth: _____

This "Preauthorization to Treat Minors" provides your consent for medical care to be delivered directly to a minor child if a parent or guardian cannot be present at the time of treatment. You may designate an adult representative (i.e., grandparent, babysitter, etc) to accompany the child; or, if your child is age 16 and above. You may provide your consent for your child to be treated when a parent, guardian, or adult respresentative is not present. Please be advised that protected health information may be shared with the representative to whom the right to consent has been delegated to facilitate informed decision making. Please also note that the person bringing the child is responsible for any payment that is due at the time of service.

I hearby authorize Michael W. Johnston, M.D. to examine and treat my minor child when he/she is accompanied by: _____

Relationship to Patient: _____

I understand that I may revoke this consent at any time by providing written notice to Michael W. Johnston, M.D. Absent written revocation, this authorization shall remain in full force and effect.

_____ _____ _____ _____

Parent/Legal Guardian Signature | Parent/Legal Guardian Name (PRINT) | Date | Time

_____

Relationship to Patient

----------OR----------

Complete the next section if your child is age 16 or above, and you authorize us to provide treatment when a parent, guardian, or adult representative is NOT present.

I authorize Michael W. Johnston, M.D. to examine and treat my minor child, age 16 or older: _____ birthdate: _____, when he/she is unaccompanied by an adult.

I understand that I may revoke this consent at any time by providing written notice to Michael W. Johnston, M.D. Absent written revocation, this authorization shall remain in full force and effect.

_____ _____ _____ _____

Parent/Legal Guardian Signature | Parent/Legal Guardian Name (PRINT) | Date | Time

_____

Relationship to Patient