



Kristin Andrade, M.D., Inc.



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**Medical Release:
Special Authorization Form for Minors**

I, _____, authorize the following name person/persons to authorize medical treatment for my child/children by this facility.

I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.

I understand that I may terminate this authorization form. I must notify this facility in writing regarding termination and effective date.

Name of personal representative:

Relationship:

Name of children:

Birthdate:

Signature: _____

Date: _____

Printed Name: _____

Relationship to child: _____