WOODCREEK HEALTHCARE

Puyallup Office • 1706 S Meridian • Puyallup, WA 98371
Sunrise Office • 11102 Sunrise Blvd E, Ste 103 • Puyallup, WA 98374
Bonney Lake Office • 10004 204th Ave E, Ste 1300 • Bonney Lake, WA 98391

Authorization for Health Care of a Minor

Patient Name ______________________________________ Date of Birth ____________________
Last First MI mm/dd/yyyy

I, the parent or legal guardian of the minor child listed above, hereby authorize the persons listed below to make health care decisions for my minor child.

AUTHORIZED PERSONS

Name ______________________________________ Relationship to Child ____________________

Name ______________________________________ Relationship to Child ____________________

Name ______________________________________ Relationship to Child ____________________

This declaration is effective as noted below, or no more than six (6) months from the date on which it is signed, or until revoked in writing by the parent or legal guardian.

All requests to revoke or amend this authorization must be completed in writing.

Valid from ____________________ to ____________________

PARENT/LEGAL GUARDIAN SIGNATURE

____
Print Name

____
Relationship to Minor (parent, guardian, or other legally authorized individual)

____
Address: Street or P.O. Box

____
City, State, ZIP

____
Phone

____
Signature

____
Date