QUICK CARE MED
WALK-IN CLINIC & URGENT CARE
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Lecanto, FL 34460
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# Letter of Consent/Authorization For Minor Child

**Patient Information:**

First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: ___/___/_____

**Parent/Legal Guardian Information:**

First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: ___/___/_____ Phone: _____-_____-_____

Driver's License#: _____ Relation to Patient: _____

Present address: _____

City: _____ State: _____ ZIP: _____

**Authorized Person:**

First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: ___/___/_____ Phone: _____-_____-_____

Driver's License#: _____ Relation to Patient: _____

Present address: _____

City: _____ State: _____ ZIP: _____

I, _____ hereby authorize _____ as my selected authorized person to give consent for any medical treatment that may be required for my child (Name of Minor Child) _____ in the event of my absence.

This Letter of Consent/Authorization is being submitted as a formal document for the specific purpose of allowance for the medical care and services provided by QUICK CARE MED, LLC. I further declare that all communication and supervision of my child will be the sole-responsibility of my selected person.

As parent/guardian, I shall absorb all primary responsibilities for providing medical insurance coverage and all out-of-pocket and self-pay expenses for any and all medical services of my child's medical care.

**Print Name of Parent/Legal Guardian:** _____

**Signature of Parent/Legal Guardian:** _____

**Date:** _____

Photo ID of Parent/Legal Guardian and Authorized Person must be provided to QUICK CARE MED, LLC.