SANTA ROSA ORTHOPAEDIC ASSOCIATES, P.A.

MINOR AUTHORIZATION TO TREAT AND RELEASE PROTECTED PATIENT MEDICAL INFORMATION

Minor Name: _____

Minor Date of Birth: _____ Misys Account # _____

I, _____, authorize Santa Rosa Orthopaedics and any of its medical staff to treat my son/daughter, _____, while under the age of eighteen.

I, _____, authorize Santa Rosa Orthopaedics and any of its employees to release the minors protected medical information to the following.

Answering Machine # _____

Name:	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
Legal Guardian Signature	Date
_____	_____
Witness Signature	Date

***Attach copy of Legal Guardians' Driver License**