Michigan Teen Health Authorization Pack
For use by parents/guardians of Michigan minors ages 13â 17

Minor Medical Treatment Authorizatio

I, _____, am the parent or legal guardian of _____, a minor child, born on _____.

I authorize the following adult to consent to and obtain medical or dental care for the above-named child in my absence:

Authorized Adult: _____
Address: _____
Phone: _____ Relationship: _____

This authorization includes consent to examination, diagnostic procedures, anesthesia, surgery, and other medical treatment that a licensed physician or dentist deems necessary for the health and safety of my child.

This authorization shall remain in effect until _____, unless revoked in writing earlier by me.

I release all medical personnel and facilities from liability in acting under this authorization and accept responsibility for all expenses incurred.

Parent/Guardian Name (print): _____
Parent/Guardian Signature: _____
Date: _____
Address: _____
Phone: _____ Email: _____

Notary Acknowledgment

State of Michiga
County of _____

Subscribed and sworn before me on this _____ day of _____, 20____, by _____ (Parent/Guardian).

_____
Notary Public, State of Michigan, County of _____
My commission expires: _____
Acting in the County of _____

HIPAA Authorization for Parent / Guardian Access

I, _____, hereby authorize my health-care provider(s) and any hospital, clinic, or health-care facility to disclose and discuss my protected health information (PHI) with my parent or legal guardian identified below:

Parent/Guardian Name: _____
Relationship: _____
Address: _____
Phone: _____ Email: _____

This authorization allows discussion and receipt of information related to my medical condition, treatment, billing, and appointments. I understand that:
- I may revoke this authorization at any time by written notice.
- Revocation does not affect disclosures made before revocation.
- This authorization will expire on _____, unless revoked earlier.
- My signature below is voluntary and made under Michigan law.

Patient (minor) Name: _____
Date of Birth: _____

Patient (minor) Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

Emergency Medical Information Sheet

Childâ s Full Name: _____
Date of Birth: _____ Age: _____
Address: _____
Parent/Guardian Name: _____
Phone (home): _____ (cell): _____
Email: _____

Emergency Contact (if parent unavailable):
Name: _____
Relationship: _____
Phone: _____

Physician / Clinic: _____
Phone: _____

Allergies (medication, food, environmental):
_____
_____

Current Medications / Dosage:
_____
_____

Insurance Company: _____
Policy Number: _____ Group #: _____

Special Medical Conditions / Notes:
_____
_____

Parent/Guardian Signature: _____ Date: _____