

**DIMOND
MEDICAL CLINIC**

300 East Dimond Blvd.
Anchorage, AK 99515
Phone: 341-7757
Fax: 341-7760

ALASKA MEDICAL CLINICS, LLC



**WASILLA
MEDICAL CLINIC**

1700 E. Parks Hwy. #200
Wasilla, Alaska 99654
Phone: 373-6055
Fax: 373-6077

**AUTHORIZATION AND CONSENT FOR TREATMENT OF A
MINOR**

I undersigned parent or guardian, of a minor: _____
(print name of minor)

who has _____
(pertinent allergies or other medical conditions)

do hereby authorize Alaska Medical Clinics (Wasilla or Dimond Medical Clinic), as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any licensed physician or physician assistant whether the diagnosis or treatment is rendered at the office of the physician or at the hospital.

This authorization specifically includes hospital admission if such is deemed necessary by the physician. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a provider, in the exercise of his or her best judgment may deem advisable.

This authorization shall remain in effect from _____ to _____
Unless revoked sooner in writing and delivered to said agent(s).

Date

Time

Signature of Parent or Guardian

Home Phone Work Phone

Signature of Witness

Signature of Witness (*If consent for treatment of minor is obtained by telephone, a second witness is required.)