Alaska Medical Clinics, LLC
Alaska Urgent Care
300 E Dimond Blvd, #12A
Anchorage, AK 99515
P: (907)341-7757 | F: (907)341-7760

AUTHORIZATION TO TREAT A MINOR

Patient's Name: ____ Patient's Date of Birth: __________________

GUARANTOR/BILLING INFORMATION

Parent/Guardian Name ____
Date of Birth: __________________ SS#: ______________________ Sex: M F
Parent/Guardian Mailing Address: ____
City: _______________________ State: _________ Zip___________
Home Phone #: _____________________ Cell #: ________________________ Work #: ____________________
Alternate Emergency Contact: ___________________________________ Phone #: _________________________

I hereby authorize healthcare providers of Alaska Medical Clinics, LLC, dba Alaska Urgent Car, LLC to examine and treat the patient/minor. If a medical issue arises, and I am unable to personally consent to treatment, I hereby authorize and consent the following people (over the age of 18) to accompany the patient/minor. I understand that I shall be liable and agree to pay all costs and expenses incurred with medical services rendered.

Name____ Relationship to patient/minor:___________________
Date of Birth: __________________ Sex: M F
Cell #: ________________________ Work #: __________________

Name____ Relationship to patient/minor:___________________
Date of Birth: __________________ Sex: M F
Cell #: ________________________ Work #: _____________________

____ _________________________
Parent or Legal Guardian Name Print Date

____ _________________________
Patient or Legal Guardian Signature Date