Alaska Medical Clinics, LLC
Wasilla Medical Clinic
1700 E. Parks Hwy., #200
Wasilla, AK 99654
Phone: 907-373-6055 | Fax: 907-373-6071

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 Wasilla Medical Clinic 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