

**EATON RAPIDS MEDICAL CENTER  
1500 S. MAIN STREET  
EATON RAPIDS, MICHIGAN 48827  
517-663-2671**

AUTHORIZATION TO SECURE ROUTINE AND EMERGENCY MEDICAL TREATMENT

Re: \_\_\_\_\_

Full name of minor

\_\_\_\_\_  
Street address

\_\_\_\_\_  
City State Zip

I \_\_\_\_\_ give the following individuals:

Parent/Guardian full name

\_\_\_\_\_  
Full Name Relationship

\_\_\_\_\_  
Full Name Relationship

Permission to secure routine and emergency medical treatment upon my son/daughter  
\_\_\_\_\_ at Eaton Rapids Medical Center.

Minor's full name

This said minor is included in the following insurance plan: (attach copy of card if available)

\_\_\_\_\_  
Insurance company name

\_\_\_\_\_  
ID# Policy/Group#

\_\_\_\_\_  
Policy holder's full name (as it appears on insurance card)

Parent/Guardian Contact Information:

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\*Note: Phone contact is required before any services are provided in non-emergent cases.