anchorage medical services

3401 Minnesota Drive Ste 100
Anchorage, AK 99503
P. 907-677-9200
F. 907-677-9210

I, _____, am the legal guardian of _____,
(guardian name) (minor name)

currently a minor with date of birth _____.

I authorize *Anchorage Medical Services* to provide any medical care to my son/daughter determined necessary by the physicians when accompanied by _____.
(legal name is person accompanying)

This could include but is not limited to diagnostic examinations (including radiological and laboratory testing), tuberculosis screening, verification and/or administration of immunizations and necessary medical treatment (including minor surgical procedures). I understand that once my child turns 18 my consent for treatment is no longer required. I may choose to terminate this consent before it is set to expire at any time.

This authorization is valid for one year from date signed unless otherwise specified _____.

_____ _____
(Legal Guardian Signature) (date)

_____ _____
(Accompanying Party Signature) (date)