AUSTIN HAND GROUP
PARENTAL PREAUTHORIZATION FOR MINORS

For families who have established relationships with our practice, it may be convenient to have on file prior authorization for medical care for children when a parent cannot be present for treatment. Please complete the following form if you want to authorize the treatment in advance.

I request and authorize Austin Hand Group and its personnel to deliver medical care to my child listed below:

Patient Name ________________________________ Date of Birth ____________

Please try to contact us regarding the health care of our child at the following number(s):

Parent Name ________________________________ Phone ________________

Parent Name ________________________________ Phone ________________

Other ____________________________________ Phone ________________

Please contact us at 512.327.4263 to speak with our staff if you have any further questions or concerns.

Parent or Guardian Signature ___________________________ Date _______________

Relationship to Patient ______________________________