Family Care Associates of Effingham, S.C.

1106 N. Merchant St., P.O. Box 665
Effingham, Illinois 62401
217-342-7000
www.familycareassociates.com

AUTHORIZATION TO TREAT MINOR

_____ _____

Name of Child/Minor Date of Birth

_____

Name of Physician

As the parent/guardian of the above-named child/minor, I hereby give permission to Family Care Associates of Effingham, S.C. to treat the child/minor in the event that a medical emergency arises and/or I am unable to personally consent to the treatment. I also agree to be responsible to the physician for charges for medical services rendered.

_____ _____

Parent or Guardian's Name (Print Please) Date

_____

Parent or Guardian's Signature

Colleen Bingham, M.D. ***Michael G. Brummer, M.D.*** ***Jeffrey K. Brummer, D.O.***
Jeffrey G. Crowell, M.D. ***Thomas Heischmidt, M.D.*** ***Amanda Bierman, M.D.***