PARENT/GUARDIAN DENIAL FOR TREATMENT OF MINORS AND INCOMPETENTS

I, the undersigned parent/guardian of _____,
(name and age)

in the event that I cannot be contacted through reasonable efforts, hereby **deny** authorization for any medical and hospital treatment for my above named child/ward.

This denial shall be valid for the period of time commencing on _____

and ending on _____.

I will hold harmless the providers at Watertown Family Practice Associates who act in reliance upon this denial.

Executed this _____ day of _____, 20___.

_____ _____
Witness Parent/Guardian

_____
Parent

Contact Information:

Parent/Guardian may be located at the following address/telephone number:

Home Address/Telephone Number_____

_____

Cell Phone Number _____

Employer Name, Address and Telephone Number _____

_____

Any known allergies: _____

Insurance Information:

Company _____

Subscriber Name _____ Policy Number _____