JISUE K. COYE, M.D., F.A.A.P.

20911 Earl St. #100
Torrance, CA 90503
(310) 370-7759

Medical Release;
Special Authorization Form for Minors

I,_____, authorize the following named person/persons to authorize medical treatment for my child/children by this facility.

I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.

I understand that I may terminate this authorization form. I must notify this facility in writing regarding termination and effective date.

Name of personal representative:	Relationship:
_____	_____
_____	_____
_____	_____

Name of Children:	Birthdate:
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____

Printed Name: _____ Relationship to child: _____