MORONGO BASIN
COMMUNITY HEALTH CENTER
A SERVICE OF MORONGO BASIN HEALTHCARE DISTRICT

760-365-9305

AUTHORIZATION FOR ALTERNATE ADULT/GUARDIAN FOR CLINIC VISITS

The undersigned Parent/Guardian herein gives consent for the listed individuals to bring the child/minor patient to and from office visits at Morongo Basin Community Health Center

Patient's Name:	Date of Birth:
Authorized Persons	**Frequency of Authorization**
Name of Authorized Person(s):	Authorization is valid for:
Address:	❑ One time only
	❑ 6 mos: ________ to ________
Phone Number:	❑ 1 year: ________ to ________
Relationship to Child:	❑ Indefinitely
Name of Authorized Person(s):	Authorization is valid for:
Address:	❑ One time only
	❑ 6 mos: ________ to ________
Phone Number:	❑ 1 year: ________ to ________
Relationship to Child:	❑ Indefinitely
Name of Authorized Person(s):	Authorization is valid for:
Address:	❑ One time only
	❑ 6 mos: ________ to ________
Phone Number:	❑ 1 year: ________ to ________
Relationship to Child:	❑ Indefinitely
Name of Authorized Person(s):	Authorization is valid for:
Address:	❑ One time only
	❑ 6 mos: ________ to ________
Phone Number:	❑ 1 year: ________ to ________
Relationship to Child:	❑ Indefinitely
Parent / Guardian Signature	Parent / Guardian Phone
Date Signed:	
ID confirmed by CHC staff (date and initials):	