THERAPEUTIC SERVICES AGENCY, INC.

220 RAILROAD ST. SE • PINE CITY, MN 55063 • (320) 629-7600 • DEPOT FAX (320) 629-7900 • HILLTOP FAX (320) 629-0003

MEDICAL, PSYCHIATRIC, DENTAL AND OPTICAL PERMIT

(To Be Completed by Parents or Guardians)

TO WHOM IT MAY CONCERN:

I hereby authorize and give my consent to any psychiatric, dental, optical or medical care to be performed on my child while at THERAPEUTIC SERVICES AGENCY, INC. when in the opinion of the attending, duly qualified physician said services are deemed necessary or advisable. I also consent to the administration of whatever anesthetics and prescription drugs that are advisable or necessary. I hereby authorize the release of information relative to recent physical examination and/or prescription drug information in writing when deemed necessary for the treatment of my child, _____. The information may be released to THERAPEUTIC SERVICES AGENCY, INC.

Signed: _____
(Parent or Guardian)

Date: _____

MA Number: _____

BlueCross/BlueShield Number:_____

Other Insurance Policy and Policy Number:_____

Remarks/Exceptions to the above:_____

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