CONSENT: AUTHORIZATION FOR TREATMENT OF A MINOR

(One form per child)

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Mailing Address: _____

Parent/Guardian Name: _____

Patient's Personal Physician: _____ Physician's Phone Number: _____

Physician's Address: _____

Patient Medication: _____

Patient Allergies: _____

Significant Medical History: _____

Guarantor: _____ Guarantor's Employer: _____

Responsible Insurance Company: _____ Group Number: _____

Authorized Agents: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

As parent or guardian of the minor, I do hereby authorize the above named agent(s) to consent to any:

- X-ray examination
- Anesthetic
- Medical or surgical evaluation
- Diagnosis or treatment; or
- Care that is recommended, provided by or supervised under a licensed medical practitioner.

It is understood that this authorization is given in advance of any specific evaluation, diagnosis, treatment and care required. However, it is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent as described above.

This authorization also grants my agents(s) for the time period specified below, the authority to:

- Obtain copies of medical records related to this minor; and
- Sign release of information to any third party payors who may be responsible for part or all of the cost of the services provided.

This authorization shall remain effective from: _____ to _____, unless sooner revoked in writing.

Parent/Guardian Signature: _____ Date: _____ Time: _____

Relation to patient: _____

Staff Witness Signature: _____ Date: _____ Time: _____

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Patient Label