CONSENT & DISCLOSE FOR MINORS

Consent to Treat:

- Power to authorize treatment for minors when patient is not accompanied by parent / guardian.

Release of Information:

- Power to release information to include, but not limited to: prescription pick up, absence notes, other forms of communication etc.
- Any changes / updates must be initialed and dated by responsible party

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

I hereby authorize the following person(s) to consent to such medical treatment as said person may deem to be in the best interest of my minor child. I hereby authorize the following person(s) to receive otherwise protected health information regarding my minor child.

Name: Relation: Phone number:

_____

_____

_____

_____

This authorization if effective from _____ to _____

(If end date is not provided, end date is assumed one year from date signed)

Signature from Parent / Guardian: _____ Date: _____