Advance Consent for the Treatment of a Minor

Patient (Minor's name):_____

Patient's Date of Birth: _____

Patient's Account #: _____

Date: _____

I, _____, the parent or guardian of,

_____, authorize and give consent to Pullman Family Medicine to provide routine and emergency medical treatment for my child when deemed necessary by qualify medical personnel. This authorization is given in advance of any specific treatment being required and I waive my right to prior informed consent to such treatment. This authorization will be in effect until revoked in writing by me.

I addition to this consent form, I have read the "Important Information to Parents of Minor's" form and understand that my minor child has the right to consent to certain health care without a parent or guardian's consent.

_____

Signature of Parent/Guardian

Printed Name of Parent/Guardian: _____

Parent/Guardian Contact information: _____

PFM Employee Initials: _____

Updated: January 2011