CONSENT / AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

As a general rule, minors cannot consent to medical treatment. Therefore, except in special situations (e.g., emergency treatment or emancipation), a physician must obtain the consent of the parent(s) or legal guardian to treat a minor. Please complete this form. That way we will know that you have authorized the designated person(s) to make medical decisions in your absence.

In the event the undersigned parent / guardian of:

Patient Name: _____ Date of Birth: _____

is absent during a medical appointment, they do hereby empower and grant to:

_____	_____	
Name	Address	
_____	_____	_____
Relationship to patient	Phone Number	Alternate Phone Number
_____	_____	
Name	Address	
_____	_____	_____
Relationship to patient	Phone Number	Alternate Phone Number
_____	_____	
Name	Address	
_____	_____	_____
Relationship to patient	Phone Number	Alternate Phone Number

the right to consent permission of any medical treatment for the minor from a qualified and licensed physician of Kids Health Partners, LLC.

This authorization shall be valid until I provide revocation to Kids Health Partners, LLC in writing. I do hereby indemnify and hold harmless the physicians and other persons who act in reliance upon this authorization.

Executed this _____ day of _____, 20_____. _____

Signature of Parent / Guardian

Parent/Guardian Contact Information:

_____	_____	_____
Name of Parent / Guardian	Phone Number	Alternate Phone Number
_____	_____	_____
Name of Parent / Guardian	Phone Number	Alternate Phone Number