



**Consent for the Treatment of a Minor**

Minor's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Account Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I hereby authorize the care of the above named minor, which in the opinion of the attending health care provider, requires diagnostic and/or medical treatment.\*  
This release form is for the sole purpose of authorizing medical treatment in the absence of a parent or guardian and **expires on December 31<sup>st</sup> of this year.**

Parent/Guardian's Name: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Address: \_\_\_\_\_

Parent/Guardian's Phone: \_\_\_\_\_

(Indicate if Home, Work or Cell)

***In my absence, the following people have my permission to give medical consent:***

Name: \_\_\_\_\_

Relation to minor: \_\_\_\_\_

Phone number: \_\_\_\_\_

Name: \_\_\_\_\_

Relation to minor: \_\_\_\_\_

Phone number: \_\_\_\_\_

Name: \_\_\_\_\_

Relation to minor: \_\_\_\_\_

Phone number: \_\_\_\_\_

***\*Immunizations and allergy injections require a separate informed consent by a parent/guardian. A separate consent is needed for additional testing or invasive procedures. Parent/guardian(s) are responsible to follow-up with their minor's provider regarding the results of the medical examination.***



\*CONS MINOR TX\*