Consent to Treat Minor – Without Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian there must be written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name: _____ **DOB:**_____
Last First Middle

(One Patient Per Form)

Parent or Legal Guardian: _____ **DOB:**_____

Parent or Legal Guardian: _____ **DOB:**_____

For those occasions when you may not be with your child, **please list those individuals who may give us consent** to see and treat your child:

Name	Relationship to Patient	Telephone
Name	Relationship to Patient	Telephone

LIMITATIONS:
Identify any **specific limitations** on the kinds of medical services for which this authorization is given. If none, then state "none."

_____

_____

This Shall Be in Effect For: □ **Date**_____ **ONLY**
□ **No Expiration Date,** unless revoked by written communication

AUTHORIZATION:
I, (parent/legal guardian name) _____request and authorize Heartland Health Services and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Heartland Health Services and its personnel to deliver routine medical and mental health treatment and services to my child. Routine medical and mental health care and interventions may include, but are not limited to: evaluation, physical exam, routine immunizations, injections, x-rays, prescription pick-ups, laboratory work (i.e.: throat or nasal swabs, blood samples, urine tests, wart treatment with liquid nitrogen, minor burns, minor suturing.)

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in a language that I can understand.

_____
Parent or Legal Guardian Signature Relationship Date

Signature of Heartland Health Services Representative: _____

I hereby revoke permission for the above individual(s) to give consent for treatment of the listed minor.

_____
Print Name **Signature** **Date**

Signature of Heartland Health services Representative: _____