Martin Foot and Ankle

MEDICAL CONSENT AUTHORIZATION FOR MINORS

I, _____am the:
(name of consenting individual)

- ☐ Parent of the child listed below and there are no court orders now in effect that would prohibit me from giving consent.
- ☐ Legal guardian or legal custodian of the child by court order (copy included) and there are no other court orders in effect that would prohibit me from giving consent.

I give the following person(s) the power to consent to necessary medical treatment of (name of minor):

_____

- ☐ **I do not give any power to consent to anyone other than myself**

Delegated Individual #1:

_____ _____
(printed name) (signature)

_____
(address)

May consent to:
- ☐ Medical treatment
- ☐ In office surgical procedures

The above-mentioned Delegated Individual:
- ☐ May go into the room with my child
- ☐ May not go into the room with my child
- ☐ May have access to any/all records including, but not limited to: insurance records regarding any such services.

Delegated Individual #2:

_____ _____

(printed name) (signature)

_____

(address)

May consent to:

- ☐ Medical treatment
- ☐ In office surgical procedures

The above-mentioned Delegated Individual:

- ☐ May go into the room with my child
- ☐ May not go into the room with my child
- ☐ May have access to any/all records including, but not limited to: insurance records regarding any such services.

I confer the power of consent freely and knowingly in order to provide for the child and not as the result of pressure, threats or payments by any person or agency.

This form is in effect until the minor reaches 18 years of age. I understand I have the right to revoke or make changes to this consent should I wish to do so.

Printed Name Parent/Guardian/Custodian: _____

Parent/Guardian/Custodian Signature: _____

Date/Time: _____

Witness Printed Name: _____

Witness Signature:

_____

Date/Time: _____