

Consent for Treatment of Minor

Patient Name:	Birth date: Age _____	Male () Female ()	Date:
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To facilitate medical care and treatment of the child, _____ (“Minor Patient”), by the undersigned parent or legal guardian of the Minor Patient hereby agrees as follows:

I am a parent or legal guardian of the Minor Patient authorized to make health care decisions on behalf of the Minor Patient.

I authorize PANIRA Healthcare Clinic to engage in the following acts: to provide the Minor Patient with emergency, urgent and other medical care and treatment including laboratory tests, imaging studies in my absence. (This allows a minor patient to come to an appointment (s) unaccompanied by parent / guardian / parent substitute.)

() Appointment of Parent Substitute to Authorize Care and Treatment of Minor Patient:

I authorize the Parent Substitute (s) designated below to give informed consent for emergency, urgent, and other medical care and treatment for the Minor Patient.

Name	Relationship to Minor	Phone Number

() **Release of Information:**

To ensure that the Parent Substitute has access to Protected Health Information needed to make informed consent decisions, I authorize **PANIRA Healthcare Clinic** to provide the Parent Substitute with Protected Health Information relating to the Minor Patient.

This authorization is valid for one-year from date signed. This authorization may be revoked at any time by providing written notice to _____

I have carefully read and considered this consent from before signing it.

() **Signature of Parent of Minor, or**

() **Signature of Legal Guardian**

Witness Name

(Print) _____

Signature of Parent/Legal Guardian

Date

Signature of Witness

Date