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