# Authorization for Treatment of Minors

## (In Parents Stead)

**Office Location:** ______________________________________________

**Patients Full Name:** ______________________________________________
LAST FIRST MI DATE OF BIRTH

By law, for certain consent areas, a 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, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

I, **the Biological Parent or Legal Guardian** (Legal Guardianship requires written proof) of the above-named child grant permission for IHA to provide medical treatment as necessary for my child's health, including evaluations, administering vaccinations, perform diagnostic procedures and provide medical treatment as deemed necessary by the Attending Provider.

I authorize IHA or their representatives to act on my behalf, in providing my child such care in my absence. I will be responsible to provide IHA with up to date pertinent history and condition information prior to each appointment and to make arrangements to receive follow up instructions and treatment plans.

**In addition, I authorize the following person(s) to accompany my child to the appointment and to make such medical treatment decisions as listed above, in my absence:**

Name: ________________________________ Relationship: __________________ Phone____________

Name: ________________________________ Relationship: __________________ Phone____________

Name: ________________________________ Relationship: __________________ Phone____________

☐ Check here if you wish to grant consent for minor identified above (minor must be 16 or older) to receive follow up (not initial) medical care without an accompanying adult.

☐ This consent shall be in effect for only the following date of service: _______/_______/_______

I understand that I may revoke this agreement at any time by notifying the providing location in writing, and it will be effective on the date notified, except to the extent that action has been taken in reliance on it. I understand that I am responsible for all reasonable charges in connection with the care and treatment of my child listed above.

______________________________________________________________
**Parent or Legal Guardian Name (please print)** **Relationship** **Date of Birth**

______________________________________________________________
**Parent or Legal Guardian Address** **Phone Number**

______________________________________________________________
**Parent or Legal Guardian Signature** **Date**

**PRESENTED ID:** ______________________ **VERIFIED BY:** ______________________

**PROOF OF LEGAL GUARDIANSHIP:** ______________________ **PROVIDER REVIEWED:** ______________________ **DATE:** __________