Children's MINNESOTA

AUTHORIZATION TO CONSENT TO TREATMENT

Dear Parent(s): State law requires that you consent to most medical treatments for your minor child. If an adult other than your child's parent or legal guardian accompanies him/her to office visits or your child is of legal driving age and will be coming to appointments without you, we will be unable to provide treatment without your written authorization, except in emergency situations.

To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child or for your child to attend visits without you, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

PART I. AUTHORIZATION

I, _____ authorize the following individual(s)
(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child listed below:

Name: _____ Date of birth: _____

AND /OR

I, _____ authorize my minor child of legal driving age
(Name of Parent or Legal Guardian)

to attend appointments on their own. Consent for care is still required by a legal guardian.

PART II. LIMITATIONS

If time limitations are not specified below, authorization of this form will continue for one year.

_____

PART III. PARENTAL CONTACT INFORMATION

If the nature of the medical care is outside the initial reason for the appointment, we will attempt to contact a parent or legal guardian regarding the health care of the child listed at the following telephone number(s).

If we are unable for any reason to contact a parent or legal guardian, we may rely on the delegate decision maker for consent.

Parent's Name: _____
Cell Phone: _____
Work Phone: _____
Other Phone: _____

Parent's Name: _____
Cell Phone: _____
Work Phone: _____
Other Phone: _____

PART IV. SIGNATURE

_____ _____
(Signature of Parent or Legal Guardian) Date

CON/WAIV

PLACE PATIENT LABEL HERE