Medical Consent Form For Minors (OPTIONAL)

Note: This form must be on file for our office to see/treat any patients under the age of 18 without their legal parent or guardian present. Please use this form to authorize and give consent for another adult to accompany and made medical decisions for your child/children.

Name of child/children:

1. _____ Date of Birth: _____
2. _____ Date of Birth: _____
3. _____ Date of Birth: _____
4. _____ Date of Birth: _____

By signing below, I authorize the designated representatives to authorize (Medical/Dental) treatment for my child/children by this facility.

I understand that I am responsible for services rendered for treatment and payments authorized by my personal representative.

I also understand that I may terminate this authorization form by notifying the facility in writing regarding termination and effective date.
Unless otherwise stated on this form, this authorization will remain in effect until the patient(s) turn 18 years old.

Person(s) authorized as designated representatives:

1. Print Name: _____ Relation to Patient:_____
2. Print Name: _____ Relation to Patient:_____

Authorized Signature:

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

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