CONSENT BY PROXY FOR MINOR
(Permission to Treat Form)

I, Printed Name of Parent/Guardian, _____ authorize

Name of Proxy: _____ Relationship to Minor(s) _____

Address: _____ _____ _____ as proxy decision maker for consenting to routine medical care for my child(ren) listed below. Additionally, protected patient health information may be shared with the proxy to facilitate informed decision making.

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Limitation:
Identify any limitations on the kinds of medical serves for proxy cannot consent. If none, state "none".
_____

This authorization is valid for six (6) months from the date of signing and may be revoked at any time providing written notice of revocation. I understand I cannot revoke this authorization retroactively for treatment already provided. I understand that instructions or information given to Responsible Party bringing in patient for visit, treatment, medication(s) will be the only information given and parent will not be called separately with information from this office. I understand that Responsible Party must be 18 years or older.

_____ I authorize my underage child/patient (16 or 17) to bring themselves in for treatment and they have the ability to understand the risks and benefits of treatment.

If the nature of the medical care is not routine, please try to contact me at the following telephone numbers. If you are unable to contact me, you may rely on the proxy decision maker for consent.

Signature of Parent/Guardian: _____ Date: _____

Telephone Number(s): _____ _____ _____