CONSENT TO TREAT MINOR

Patient Name: _____ DOB: _____

I _____ give permission to the following to accompany my child to his/her appointment
(Name of Parent/Guardian)

1._____ Relation: _____

2._____ Relation: _____

3._____ Relation: _____

This adult is authorized to provide a history of my child's present illness, disclose protected health information, and witness any physical exam completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan, or prescription(s) to me.

For minors 16-17 years old (or who turn 16 years old after the completion of this form)

By Checking this Box ☐ I _____ give permission to my child to
(Name of Parent/Guardian)
attend to his/her appointment alone without my presence and authorize treatment for my child at OLE Health. This includes providing a history of present illness, disclosure of protected health information, and the Child's responsibility for relaying any diagnosis, treatment plan, or prescriptions to me. **This excludes the administration of any immunizations**.

I agree to be available by phone to any of the phone numbers provided.

Primary phone: _____ Secondary phone: _____

I agree to be financially responsible for all copays and coinsurance.

Parent or Legal Guardian Signature: _____**Date**:_____
*Consent expires 1 year after signature date

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