Banner Health

CONSENT TO TREAT MINOR
(WHEN PARENT/GUARDIAN IS NOT PRESENT)

Name of minor patient: _____ Date of Birth: ___ / ___ / ___

Name of person giving consent: _____

Relationship to minor: _____ Phone Number: _____

Address: _____

I, _____ , (please print), do hereby state that I am the Parent/Guardian and authorize the following person(s) to bring in the minor listed above to scheduled appointment when I am not available. I authorize these person(s) to be able to give consent for the patient to be examined as well as routine and emergency health care for the patient in my absence. This consent shall remain effective for twelve months from date of signature or until revoked in writing by me as the Parent/Guardian.

Consent given to:

Name: _____ Relationship: _____

Phone Number: _____

Consent given to:

Name: _____ Relationship: _____

Phone Number: _____

Consent given to:

Name: _____ Relationship: _____

Phone Number: _____

If someone brings the child in who is not on the list, we will have to call to verify that the Parent/Guardian gives permission for the child to be treated. Two office staff members will verify the verbal consent.

_____ ____ / ____ / ____

Parent/Guardian Signature Date

_____ _____

Witness Date / Time

_____ _____

Witness Date / Time

Patient financial responsibility is due at the time of service.

12220002 Consent