



Child's Name:	_____
Date of Birth:	_____
MR #:	_____

Consent to Treat for Minor Patients

For non-emancipated minors less than 18 years old

By signing this form I acknowledge that I am the parent/legal guardian of

_____, and I agree to allow my child to receive medical care
(Child's name)

in the **Lifetime Health Medical Group Centers/Medical Offices**. This consent applies to routine medical care including, but not limited to, physical exams, routine testing, office treatments, standard vaccinations, and any counseling related to the visit. I understand that no interventions or treatment will be performed without attempts to discuss with a parent/guardian first.

Phone number of parent/guardian: _____

Exceptions to this would be the need for any emergent/urgent medical care. **In my absence I will allow the following individuals to act on my behalf and give consent for any medical treatment my child may**

require: (Names of people who can act on my behalf) PLEASE PRINT LEGIBLY

- 1. _____
- 2. _____
- 3. _____
- 4. _____

I consent to my child being seen by a provider of Lifetime Health Medical Group unaccompanied by a parent/legal guardian or above listed adult. Yes No

Limitations on the time frame for this authorization (if none, state "none"): _____ or on the date child reaches the age of majority.

I understand that I have the right to revoke this authorization, in writing, at any time, (Requests to revoke an authorization must be directed to the attention of the Lifetime Health, Health Information Department.)

I agree with the information contained above and give consent for treatment of my minor child.

Parent or Guardian Printed Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____