Minor Treatment Authorization

This form grants authority to a designated adult to provide and arrange for medical care for a minor, where the minor is not accompanied by parents or legal guardians.

Please PRINT (except signatures) and provide complete information in each section.

Patient Name: _____ Date of Birth: _____

Gender: _____ Patient Address: _____

I, the undersigned, hereby grant the following designated adult(s) permission to:

- ❑ Obtain medical treatment and procedures for this child as may be appropriate in emergency or non-emergency circumstances, including treatment by physicians, hospital and clinic personnel, and other appropriate healthcare providers, including but not limited to x-rays, blood transfusions, anesthetic, medication or other procedures necessary for diagnosis or treatment of my child.
- ❑ Obtain routine medical treatment from appropriate healthcare providers including but not limited to vaccinations, medications, physicals, lab work and any other procedures necessary for diagnosis or treatment of my child.
- ❑ The designated adult has a right to access medical records for the minor child.

I understand by signing this form it may be necessary for Regional Family Health/Regional Medical Center to share medical information concerning the patient named above to the following individuals:

Name	Relationship to Patient

- ❑ I, the undersigned, hereby grant permission for my minor child to receive medical or Behavioral Services care in my absence. I understand that I must remain available by phone through the duration of the appointment. My contact number is: _____

Expiration: This agreement will begin on _____, and shall remain effective until terminated by the undersigned or the minor reaches the age of majority.

_____ _____

Signature of Parent / Legal Guardian Date

_____

Complete Mailing Address / Street / PO Box City / State / Zip Code

_____ _____

Witness or Notary Public Signature Date

Notary Public Seal:

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