Regional Medical Center
709 West Main Street, PO Box 359
Manchester, IA 52057-0359
Phone: 563-927-7433 Fax: 563-927-7927

Minor Treatment Authorization

Regional Family Health
709 West Main Street, PO Box 359
Manchester, IA 52057-0359
Phone: 563-927-7777 Fax: 563-927-7660

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

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: