PERMISSION TO TREAT MINOR WITHOUT PARENT/LEGAL GUARDIAN PRESENT

I, ______________________________________ as Parent / Legal guardian of:
name

____
name of minor child

give consent for any of the caregivers at Aultman Family Medicine to access, care and provide treatment to the minor child named above in my absence. This permission and consent complies with the Patient Agreement that I signed authorizing medical treatment for my minor child.

I understand that the cost of care and treatment provided to my minor child will be billed to my insurance company and/or to me.

My minor child may be accompanied by the following people to an appointment at Aultman Family Medicine:

____

________________________________ List names of people who may

________________________________ bring your minor child to an appointment.

____

____

I understand that, if my minor child presents for an appointment with a person not named on the above list, I will be contacted by Aultman Family Medicine before care or treatment is provided to my minor child.

________ This consent is valid for one (1) year unless revoked in writing.
Initial

Signature: ________________________ Witness: ________________________

Print Name: ________________________ Print Name: ________________________

Date: ________________________ Date: ________________________