



EVALUATION AND TREATMENT OF MINORS

CONSENT

I, _____, the parent or legal guardian of _____,
(Name of parent/guardian) (Name of child)

allow _____ to bring my above-named child to medical appointments
(Name of adult)

with _____, and consent to the treatment of my child.
(Name of provider(s)/practice)

This consent is active:

only on _____
(Specify month, day, year)

from _____ to _____
(Specify time period)

until cancelled by me in writing.

I maintain the right to cancel this consent at any time by writing to the above named provider(s).

Signature of Parent/ Guardian

Date

Signature of Witness

Date