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 with _____________________________, and consent to the treatment of my child. (Name of adult) (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