Parental Consent Unaccompanied Minors Form

I do hereby authorize _____(entity name) to render medical and/or surgical care to my dependent child, _____.

This authorization includes routine as well as emergency treatment. If a fee is charged for services, I assume full responsibility for payment.

I authorize my insurance benefits to be paid directly to the provider and authorize the provider or insurance company to release any information required for this claim.

Consent needed for each occurrence ☐ Yes ☐ No

Consent valid until age 18 all injuries/illnesses ☐ Yes ☐ No

Consent valid only for _____ (specific visit reasons)

Consent valid through_____ (end date)

_____
Patient Name (Printed)

_____
Patient Date of Birth

_____ _____
Parent (or legal guardian) Signature Date Signed

_____
If signed by person other than patient, please provide printed name, reason, relationship to patient, description of their authority

PLACE PATIENT LABEL HERE