



NAME: _____
 MRN: _____
 (Patient Label)

Parental Authorization to treat Minor Child When not accompanied by Parent or Guardian

We must have permission from a child’s parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian. If you feel there may be an occasion where your child will be brought by a relative, sitter, etc., please fill out the following information for us to include with your child’s records.

Patient’s Name _____ **Date of Birth** _____

The following persons have my permission to authorize medical care for my child and sign the encounter form signifying my responsibility for payment:

Name	Relationship

Patient listed above may present unaccompanied by an adult.

 Signature of Parent or Legal Guardian

 Date

 Time

 Witness Signature

 Date

 Time

 Interpreter Signature/ID# (if applicable)

 Date

 Time

This authorization will be in effect until changed by the Parent or Legal Guardian above



CONSNT