

AUTHORIZATION FOR TREATMENT OF MINOR CHILD UNDER THE AGE OF 14

Patient Name: _____ (Last) (First) (M.I.) DOB: _____ Age: _____

Authorization of Other Caregivers

I, _____, hereby consent to Dirne Health Center, Inc (“Heritage”) allowing the below caregiver(s) to make appointments for my child and bring my child to appointments at Heritage for the health care services authorized below when I am not present. *(Initial all that apply)*

_____ Caregiver’s Name	_____ Relationship to Child	_____ Phone Number
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Consent to Services

I consent to Heritage providing the following health care services regardless of whether I am present *(Initial all that apply)*:

<input type="checkbox"/> Preventative Care Services, including well checks, hearing screens, vision screens, screening labs, developmental screenings, mental health screenings.	<input type="checkbox"/> General Primary Care Services, including management of asthma, eczema and other similar conditions and evaluations for autism, learning disabilities, ADHD and other similar conditions.	<input type="checkbox"/> Medication Management, including prescribing and filling medication.
<input type="checkbox"/> Vaccines	<input type="checkbox"/> Acute Illness, including cold and flu symptoms, sore throat, urinary tract infection, abdominal pain, and any other similar conditions.	<input type="checkbox"/> Contraceptive Care Services, including prescribing birth control, treatment of menstrual irregularities, and other similar care.
<input type="checkbox"/> Dental Services, including routine cleanings, fillings, x-rays, and other similar care.		
<input type="checkbox"/> Other(s): _____		

Acknowledgements

(Parent Initials) If I have questions regarding any health care services consented to under this form, I will contact Heritage to address the questions. I understand that the practice of medicine is not an exact science and no promises or guarantees have been made nor can they be made to me concerning the outcome of the health care services. I understand if I have any questions regarding this authorization or about the services offered that I may discuss them with my child’s health care provider.

By signing below, I acknowledge I have read and I understand the above. I declare that I am the minor child’s biological parent, adoptive parent, or the individual granted exclusive right and authority over the welfare of a minor child under state law. I understand that I may revoke this consent at any time, except to the extent that services have already been rendered. To revoke this authorization, I further understand that I must provide written notice to Heritage. There are no penalties for revoking consent.

Parent’s Full Legal Name (please print) Signature Effective Date

Witness’ Full Legal Name (please print) Signature Effective Date

This form will expire one year from the Effective Date.