Consent to Treat a Minor

Community Health Connection, Inc. (CHC) must receive permission from a minor's parent or legal guardian before providing treatments for an injury or illness that is non-life threatening. This form gives CHC legal permission to treat your child in case you cannot accompany him or her to CHC for treatment. If the party accompanying your child (babysitter, friend, relative, etc.) does not present this information or this information is not currently on file, CHC will attempt to contact you to request permission to treat your child. If we are unable to obtain permission to treat the child, the child's appointment will be re-scheduled.

NOTE: A parent or legal guardian must attend a minor's first visit at CHC. A legal guardian(s) must have proper documentation and picture ID at first appointment.

AUTHORIZATION:

Patient Name: _____ Date of Birth: _____

Account Number: _____ Sex: ○ Male ○ Female

I/we, hereby authorize the person(s) listed below (an adult(s) into whose care the minor has been entrusted) to arrange for and authorize routine medical treatment at CHC clinics from _____(start date) to _____(end date).

Authorized Persons Name	Relationship
Authorized Persons Name	Relationship

I/we realize that every effort will be made to contact us at the earliest convenience and it is my/our desire by this letter of authorization that medical treatment not be delayed by inability to contact us first.

I/we accept full financial responsibility for all medical and health care rendered in response to this letter of authorization.

Parent or Legal Representative (please print)*	Parent or Legal Guardian Signature	Date
Parent or Legal Representative (please print)*	Parent or Legal Guardian Signature	Date

**May be requested to show proof of representative status.*

File in Patient Chart

Community Health Connection Medical Services