Isleta Health Center
1 Sagebrush St. · P.O. Box 580
Isleta, NM 87022
Phone: 505-869-3200

PARENT / LEGAL GUARDIAN AUTHORIZATION FOR MINOR TO RECEIVE CARE AT ISLETA HEALTH CENTER

This form gives your authorization for a non-parent/non-guardian to accompany your minor patient to appointments and to authorize care during appointments/walk-in visits. **Signing this form does not authorize release of medical records.** ***Please fill out both sides of form.***

PART A: Minor Patient Information

First Name _____ Middle _____ Last Name _____

Address _____ City / State _____ Zip _____

Date of Birth _____ ( ) Home Phone _____

PART B: Your Rights

YOUR RIGHT TO REVOKE: You may revoke this authorization at any time by giving written notice to Isleta Health Center. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. Please contact Isleta Health Center for more information if you desire to cancel this authorization.

PART C: Authorization to Accompany Minor

1. I authorize the person(s) named on the back of this authorization form to accompany/make decisions regarding the following health services for my child:
   a. Regular health care, including but not limited to medical examinations, routine laboratory studies, immunizations, and physical therapy evaluation and treatment.
   b. Dental care, including but not limited to dental examinations, preventive use of fluorides, necessary emergency dental care, and extractions.
   c. Eye related services including eye examinations and treatments.
   d. Emergency health care for accidents or illness.
2. The person(s) named on the back of this form has/have agreed to accompany and make decisions regarding the health services listed above.
3. I understand my authorization will remain in effect for the length of the time specified below:

   ☐ **Expiration date (not to exceed one year; form must be completed yearly):**

   From _____ / _____ / _____ ***To*** _____ / _____ / _____
   Beginning Date End Date

PATIENT IDENTIFICATION

Authorization for Minor to Receive Care

4. Authorized Patient Representative Information:

A.

First Name _____ Middle _____ Last Name _____

My Representative's Relationship to Me _____

( ) Home Phone _____ ( ) Alternative Phone _____ Date of Birth _____

B.

First Name _____ Middle _____ Last Name _____

My Representative's Relationship to Me _____

( ) Home Phone _____ ( ) Alternative Phone _____ Date of Birth _____

C.

First Name _____ Middle _____ Last Name _____

My Representative's Relationship to Me _____

( ) Home Phone _____ ( ) Alternative Phone _____ Date of Birth _____

I, _____ (Please print), having had full opportunity to read and consider the contents of this authorization, confirm my agreement for the above named person(s) to accompany my minor child as named on this form.

Parent/Legal Guardian Signature: _____ **Date:** _____

IHC Staff Signature: _____ **Date:** _____

PATIENT IDENTIFICATION