



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

- 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:
 - Regular health care, including but not limited to medical examinations, routine laboratory studies, immunizations, and physical therapy evaluation and treatment.
 - Dental care, including but not limited to dental examinations, preventive use of fluorides, necessary emergency dental care, and extractions.
 - Eye related services including eye examinations and treatments.
 - Emergency health care for accidents or illness.
- The person(s) named on the back of this form has/have agreed to accompany and make decisions regarding the health services listed above.
- 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, _____, having had full opportunity to read and consider the contents of
(Please print)
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