# CONSENT FOR TREATMENT OF A MINOR

Patient Name: _____ DOB: _____

**Child/Family Representative Consent to Treat without a Parent/Guardian Present**

I (Parent/Guardian Full Name)_____give permission to (Authorized Individual's Full Name)_____to make medical decisions regarding medical treatment on my behalf and also have access to all medical/billing information for my minor child (Child's Full Name)_____at Great Lakes Pediatric Associates PLLC.

I hereby give my permission to release any and all medical/billing information regarding the patient listed above to the following individuals:
**(List Name and Relationship)**

_____

_____

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**This authorization is valid from the date of signature until written notification is given to cancel this request.**

_____

Parent/Guardian Signature Date