**Parental Consent for Treatment of Minor Without Parent Present:**

Initial Here: \_\_\_\_

I hereby allow for the below minor child to receive medical treatment at New medical without my presence. If circumstances permit and state and federal privacy laws allow, I would like to have the provider consult in connection with such treatment. Please attempt to contact me at the below telephone number. This authorization shall be effective until the minor’s 18th birth date.

The above policies will remain in effect until revoked by me in writing.

Printed Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not signed by the patient, please indicate relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or guardian of minor patient Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian or conservator of an incompetent patient

FOR OFFICE USE ONLY: Reason for Inability/Refusal to obtain Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Medical Staff Signature/Name: \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_