PINNACLE
Family Health Care

AUTHORIZATION FOR TREATMENT OF A MINOR

Patient's Name: _____ Patient's Date of Birth: _____

Name of Patient's Legal Guardian: _____

Relationship to Patient: _____

Option one:

I, _____, give consent for the minor, _____,

to be seen without my presence and make their own medical decisions.

Option two:

I, _____, give permission to _____,

to act as my representative and make the medical decisions for _____.

☐ For this date only

☐ For all appointments.

_____ _____

Signature **Date**