Kentucky Mountain Health Alliance, Inc.

Treatment Authorization for Minor

Minor Name: _____ DOB: _____

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant authorization and consent for the below listed individual(s) to authorize Kentucky Mountain Health Alliance, Inc. staff to provide treatment to the above named minor.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or care being required and is given to provide consent to treatment in my absence or incapacitation.

The adult accompanying the minor child must have a current, reliable method of contacting the parent/legal guardian if needed.

List names of individuals you give authorization to consent for medical/dental treatment of the minor child.

1. _____ (Relationship) _____
2. _____ (Relationship) _____
3. _____ (Relationship) _____

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s), or until the child may legally consent for him/her self.

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Staff Signature Date