

Authorization to Treat a Minor

I, the undersigned, hereby authorize providers at CCMH Medical Clinic to provide medical treatment and/or surgical treatment to my child.

I further authorize the following people acting on my behalf to consent to such medical and/or surgical treatment as CCMH Medical Clinic's medical providers may deem medically necessary or advisable for my child.

Parent/Guardian's Name: _____ Relationship to Child: _____
(Print Name)

Parent/Guardian's Name: _____ Relationship to Child: _____
(Print Name)

Adult's Name: _____ Relationship to Child: _____
(Print Name)

Adult's Name: _____ Relationship to Child: _____
(Print Name)

Adult's Name: _____ Relationship to Child: _____
(Print Name)

This authorization shall remain in effect until _____ (date) and can be changed by legal parent/guardian at any time.

Information about the Child

Child's Full Name: _____ Child's Date of Birth: _____

Signature/Authorization

Parent/Legal Guardian's Name: _____ Date: _____
(Print Name)

Relationship: ()Mother ()Father ()Legal Guardian ()Other: _____

Signature: _____ Date: _____
(Parent/Legal Guardian)

Signature: _____ Date: _____
(CCMH Employee)