CONSENT FOR CHILD TO OBTAIN HEALTH SERVICES WITHOUT GUARDIAN PRESENT

PREAUTHORIZATION

I, (guardian name)____, give my consent for (child's full name)________

____(Child's Date of Birth)______________________ to receive the health

care services indicated below at (hospital/office name)____

_______ under the direction of (licensed provider name) ____

_____________.

This consent shall begin on _____________ and remain in effect through ___________________.

This consent may remain in effect for up to one (1) year from the "begin on" date. If the "through date" is blank, consent will expire one (1) year from the "begin on" date or upon receipt of your written revocation of this consent. This consent form is only to be used for minors between the ages of 15-17.

Please mark the services for which you are authorizing the child to obtain without you present:

_______Assessment, diagnosis, and treatment of minor illness and/or injury
_______Athletic, School and/or Other Routine Physicals
_______Immunizations
_______Routine Allergy Immunotherapy (allergy shots)
_______Behavioral Health Treatment
______Procedure (Please describe) ____
______Other (Please describe) ____

____

Phone number where I can be reached during the provision of health services: _____________________

____
Authorization Signature – Parent/Legal Guardian

____
Printed Name – Parent/Legal Guardian

____
Relationship to Patient

____
Witness – Mission Partner and/or notary

____
Date/Time