Parental Consent Form

Date: _____

AUTHORIZATION FOR TREATMENT OF MINOR CHILD

I, _____ parent/legal guardian of _____

_____ minor child, authorize treatment by any physician of Medical Park Family Care, Inc.

_____

Signature of parent/legal guardian

AUTHORIZATION FOR TREATMENT OF MINOR CHILD – ABSENCE

I, _____ parent/legal guardian of _____

_____ minor child request that he/she be allowed to be seen by a physician at MPFC if accompanied by the following named adult:

Name: _____

Date of Birth: _____

Relationship to Minor: _____

AUTHORIZATION FOR TREATMENT OF MINOR CHILD AGE 17-ABSENCE

I, _____ parent/legal guardian of _____

_____, **of the AGE OF 17,** request that he/she be allowed to be seen by a physician at MPFC for treatment without parent/legal guardian present.

_____

Signature of parent/legal guardian

I agree to be fully and completely financially responsible for all incurred charges. I understand that the physician always has the option to refuse service if he/she feels it is in the minor's best interest that I am present. I further agree to be available by phone if needed during the appointment time.

This authorization is effective until the minor whose name is listed above becomes an adult or that I notify MPFC in writing of any change.

_____

Signature of parent/legal guardian

Contact Phone Number: _____

Date of Birth of parent/legal guardian: _____