Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

Authorization to Consent for Treatment of a Minor Patient
When a Parent or Legal Guardian is Not Present

I, _____, parent or guardian of

_____, a minor, authorize the following person(s) listed below as my agent(s) to consent to any x-ray examination, anesthesia, medical or surgical evaluation and/or treatment, and diagnosis or care which is deemed advisable by, and is to be performed under, the general or special supervision of a licensed physician. This authorization includes hospital admission if the physician feels it is in the best interest of the patient.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Additionally,

_____ (initial) I authorize my agent(s) to consent to immunizations.

This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided.

This authorization will be effective from today until _____/_____/_____. This authorization can be ended at any time by telling SCHC in person or in writing.

_____/_____/_____ _____
Date Signature of parent, guardian, or other legal representative

Patient Information for Minor Listed Above

Patient Name: Date of Birth: _____/_____/_____
Home Address:
Current Medication(s):
Allergies:
Parent/Guardian Name(s): 1. _____ Relationship: _____ Phone Number: _____ 2. _____ Relationship: _____ Phone Number: _____
Primary Insurance Company:
Policy Holder:
Address (if different from above):
Insurance ID Number: Group Number: