Orange City Area Health System

Written Consent for Medical Treatment of a Minor

In the event that my child/dependent, _____
Print Name Birthdate
reports to the Orange City Area Health System for medical care, I do hereby consent to such clinic care, including diagnostic procedures and medical treatment deemed appropriate by the Orange City Area Health System medical staff. I also authorize the Orange City Area Health System to release health and accident insurance information to any physician, hospital, or other medically related facility involved in my child's/dependent's treatment, in addition to such information as may be necessary for the completion of my child's/dependent's insurance claims as a result of treatment received at the Orange City Area Health System.

This is consent for us to see a minor patient. If your son/daughter requires any immunizations, procedures, laboratory testing, radiology services, allergy treatment, injections, etc the medical staff will need to get consent prior to treatment.

_____ _____
Authorized caregiver to accompany patient Relationship to patient

_____ _____
Signature of Parent/Legal Guardian Date

I authorize use of this form from:

_____, 20_____ to _____, 20_____. (may not exceed 12 months.)
(Date) (Date)

Parent/Guardian Name _____

Address _____

_____

Phone _____

_____ _____
Signature of Staff or Adult Witness Date

Office Only:
□ Original to HIM/Scan with visit - HAR #_____.
Note: If designated time period is longer than current date of service, keep original document at Clinic Front Desk (in binder).
Enter a patient message in EMR that there is a consent on file. Use copy of original for each visit to send to HIM. NS 1603
07/26