Care of Unaccompanied Minor: Consent to Treat

AUTHORIZATION

I (we) have the legal right to authorize Obstetrics & Gynecology, South, Inc. to deliver medical treatment to my (our) child named below. I (we) authorize Obstetrics & Gynecology, South, Inc. and its personnel to deliver medical care to my child.

Patient's Name: _____ Date of Birth:_____

TIME FRAME

Please select only one of the following options:

_____ This authorization is valid and remains in effect until I revoke it in writing

_____ This authorization is valid from _____ until _____

_____ This authorization is valid for this date only: _____

I understand that I may revoke this consent at any time in writing.

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____ Date of Birth: _____

Street: _____ City:_____ State:_____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

_____ _____

Signature of custodial parent or legal guardian Date

_____ _____

Witness Signature Date

Upon receipt, this form will be scanned into the patient's electronic medical record. The scanned form then becomes the legal document from that point forward, and this original will be securely destroyed.