CAPSTONE CLINIC

Minor Consent to Treat

I, (parent/legal guardian) _____, am unable to

accompany my child (child's name) _____, to

Capstone Clinic for his/her appointment.

Therefore, I give permission as follows (check one or both):

☐ I give permission for (adult's name) _____ to accompany my child to seek treatment by any means necessary and provide consent for such treatment in my absence.

☐ I give permission for (child's name) _____ to seek medical treatment without being accompanied by a parent, guardian, or other authorized adult. (Must be 16years or older)

Patient name _____ **Date of Birth** _____

Allergies_____

Insurance Carrier _____ **Policy number**_____

Expiration of Permission:

This form is **VALID ONLY** during the following timeframe (cannot exceed one year)

Effective date: _____ / Expiration date: _____

I agree to be financially responsible for the cost of any medical care provided to my child under this Authorization.

X_____

(Print name of parent/legal guardian)

X_____ _____

(Signature of parent/legal guardian) (Date)

Witness signature_____ Date _____