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CONSENT TO TREAT MINOR

Patient's name: _____ Date of Birth: _____ SS#: _____

Patient's address: _____ City, State, Zip: _____

Student's phone #: _____ Parent Phone#: _____

I, _____, parent/parents/legal guardian of _____(name of child), do hereby consent to any medical care and administration of medications determined by a physician to be necessary for the welfare of my child while said child is under the care of the above named physicians and/or their staff.

I do hereby indemnify and hold harmless the physicians and other healthcare workers who act in reliance with this authorization.

_____ verbal consent _____ witness _____second witness

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I request and authorize the physician and/or physician's representative (name of physician) _____

to release healthcare information of the patient named above to:

Names of trainers/coaches/other physicians: _____

Other: _____

My authorization will expire:

_____ One year from this date

_____ When I am no longer receiving services from the Physicians.

I understand I This request and authorization applies to:

_____ All Healthcare information, including assessment, diagnostic impression, treatment and progress notes, discharge summary, and/or prognosis relating to the following treatment, condition, or dates: _____

I know I may cancel this authorization at any time by submitting a written request to the physician.

Signature of Patient or Representative: _____

Relationship to student if requester is not the student: _____

Date: _____