Medical Consent Form for Minor

Patient Information

Name of Minor: _____ Age: _____ Gender: _____

Parent/Legal Guardian Information

Name: _____ Relationship to Minor: _____
Phone Number: _____ Email Address: _____

Consent for Medical Treatment

I, _____ as the parent/legal guardian of _____,
hereby gives my consent for _____ to be provided by _____ .

I understand that healthcare services may include but are not limited to, medical examination, diagnostic tests, medication, and/or surgery and that such services may be deemed necessary by the healthcare provider.

I acknowledge that the healthcare provider has explained the potential risks and benefits of the treatment options and has had the opportunity to ask questions and clarify any concerns.

I understand that I have the right to ask for additional information about the proposed treatment, to refuse treatment, or to seek a second opinion.

I authorize the healthcare provider and their staff to provide medical treatment to my child, and I assume full responsibility for payment for such treatment.

I hereby authorize the release of any medical information necessary to process insurance claims or for any other legitimate purpose.

In case of an emergency, I can be contacted at the following numbers:
Home Phone: _____ Work Phone: _____ Cell Phone: _____

I hereby certify that I am the parent/legal guardian of the above-named minor and that I have the authority to give the consent as outlined above.

Parent/Legal Guardian Signature: _____ Date: _____
Healthcare Provider Signature: _____ Date: _____