Medical Consent Form for Minors

Patient information

Date:	
Name of minor:	**Age:**
Assigned sex at birth:	**Gender:**

Parent/legal guardian information

Name of parent/guardian:	
Relationship to minor:	
Phone number:	**Email:**
Address:	

Consent for medical treatment

I, ______________________________, as the parent/legal guardian of ________________________ hereby give my consent for ____ to provide the following treatment:

I understand that healthcare services may include but are not limited to medical examination, diagnostic tests, medication, and/or surgery and that such sevices 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, please contact me using the details above.

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.

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