Consent for Medical Treatment of a Minor

In the event that my child/dependent, ____

Print Name Birthdate

reports to the Orange City Area Health System for medical care, I do hereby consent to such clinic care, including diagnostic procedures and medical treatment deemed appropriate by the Orange City Area Health System medical staff.

I also authorize the Orange City Area Health System to release health and accident insurance information to any physician, hospital, or other medically related facility involved in my child's/dependent's treatment, in addition to such information as may be necessary for the completion of my child's/dependent's insurance claims as a result of treatment received at the Orange City Area Health System.

____ ______________________

Signature of Parent/Legal Guardian Date

I authorize use of this form from:

_________________, 20______ to _________________, 20_____. (may not exceed 12 months.)

(Date) (Date)

☐ Verbal Consent given by phone. Verbal consent valid only for today's visit.

Parent/Guardian
Name ____

Address ____

____

Phone ____

____ ______________________

Signature of Staff or Adult Witness Date

____ ______________________

2nd Staff Witness signature if verbal consent by phone Date

Office Only:
□ Original to HIM/Scan with visit - HAR #____________________.
Note: If designated time period is longer than current date of service, keep original document at Clinic Front Desk (in binder).
Enter a patient message in EMR that there is a consent on file. Use copy of original for each visit to send to HIM.

NS 1603
07/23/20