Consent for Medical Treatment

PATIENT INFORMATION

Name of Minor: _____ **Age:** _____

Gender: _____

PARENT/LEGAL GUARDIAN INFORMATION

Name: _____ **Relationship to Minor:** _____

Phone Number: _____ **Email Address:** _____

CONSENT FOR MEDICAL TREATMENT

I, [Insert your name], as the parent/legal guardian of [minor], hereby gives my consent for [medical treatment] to be provided by [healthcare provider].

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: _____ dd / mm / yyyy

Healthcare Provider Signature:
Date: _____ dd / mm / yyyy