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**PERMISSION FOR TREATMENT OF MINOR**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for the following people to seek and obtain medical care and treatment from Family Health Center for my child. This authorization is effective on the date signed.

Name Relationship to Child Phone #

Name Relationship to Child Phone #

Name Relationship to Child Phone #

**This authorization: \_\_\_\_\_ 1. EXPIRES ON: \_\_\_\_\_\_\_\_\_\_\_\_\_ OR \_\_\_\_\_ 2. DOES NOT EXPIRE.**

*(DATE)*

(I)(We), the undersigned, (Parents) (Legal Guardians) do hereby consent to and authorize Sandpoint Family Health Center to perform any necessary medical or surgical examination or treatment which is deemed advisable by a licensed medical practitioner at Sandpoint Family Health Center. I also understand that I am allowing the above-named caregivers the ability to make medical decisions for my child on my behalf, in my absence. This includes providing a history of present illness, disclosure of protected health information, and/or legal responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent/guardian mentioned above.

**Financial Responsibility.** I agree that I am ultimately responsible for payment for the health care services rendered to the Minor Patient and agree to comply with Sandpoint Family Health Center’s Financial Policies. See Financial Policy for details.

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Parent/Guardian Printed Name Date

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Parent/Guardian Signature Relationship to Minor