

***Authorization to Consent to Treatment of a Minor***

***Minors (under 18) must have a parent/guardian in the clinic at all times***

I,­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as the custodial parent/legal guardian of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient Full Name) (Date of Birth)

Authorize Twin Cities Orthopedics to provide health care services and treatment for the minor child named above. This authorization includes but is not limited to:

* Specialized care, assessment and treatment, as it relates to orthopedic conditions, injuries, and/or therapy.
* Primary Care treatment

**Please check the appropriate box (es) below:**

* This authorization is effective from the date signed until the treatment for this visit ends
* This authorization is effective from the date signed until the plan of care for therapy ends for this course of treatment.
* This authorization is effective for all future Primary Care treatment
* I authorize the above minor (under 18) to consent to treatment of care on their own behalf.
* I authorize the following individual(s), whom may accompany the minor to the clinic, to make treatment decisions on my behalf: (names of stepparents, grandparents, day care provider)

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# **By providing verbal consent, I indicate that I am the above minor’s legal guardian, fully**

**informed, and understand the meaning of this authorization. This authorization may be removed in writing, at any time.**

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent (signature, if available)

*CLINIC USE ONLY: If Guardian is not present, two staff members shall obtain verbal consent*

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*Verbal consent phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Verbal consent phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*