



# Authorization to Consent to Treatment of a Minor

Minors 15 and under 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.

**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 ends for this course of treatment.
- I authorize the above minor (16 or older) 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)

\_\_\_\_\_

**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.

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

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