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: _____