Medical Consent for Treatment of Minor

Patient Name:	Date of Birth: Age:____________	Male ( ) Female ( )	Date:

I, Parent/Legal Guardian/Responsible Party of the above patient, hereby consent to the medical care, examination, treatment, diagnostic studies, laboratory services, procedures, outpatient services and medications that may be performed, administered, or rendered by PANIRA Healthcare Clinic providers during this visit.

In my absence, I authorize the substitute below to accompany my child and to give consent for medical care and treatment on my behalf.

Name	Relationship to Minor	Phone Number

Release of Information:

I authorize PANIRA Healthcare Clinic to release information acquired during the medical care, examination and treatment of the child mentioned above on _________________________________**(date)** to my

- Insurance carrier for the purposes of payment for my child medical care
- Child school
- This facility and its affiliates
- Physicians (attending and consulting)
- Other allied health professionals.

____ ______________________________

PRINT FULL NAME OF PARENT/LEGAL GUARDIAN SIGNATURE

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RELATIONSHIP TO PATIENT

______________________________ _______________________________

PHONE NUMBER E-Mail address (if any)