PREMIER MEDICAL ASSOCIATES

A Member of Allegheny Health Network

Consent for Treatment of a Minor

In the Absence of Parent/Guardian

**One form filled out per minor*

Today's Date: _____ **MRN#** _____

Patient Name: _____ **Date of Birth:** _____

I (We) _____ the parent / legal guardians(s) give my (our) consent for the following authorized people to seek medical care for the child listed above in the event that I (we) are unable to be present for the appointments.

Treatment may include any necessary or routine medical treatment including but not limited to examination, injections, immunizations and/or diagnostic procedure including ordering X-ray or laboratory analysis

Authorized Person(s)

Name:_____Relationship to Minor:_____

Name:_____Relationship to Minor:_____

Name:_____Relationship to Minor:_____

Parent / Guardian

Name:_____

Relationship to minor _____

Phone: _____

Cell: _____

Signature: _____

Parent/Guardian

Name:_____

Relationship to minor: _____

Phone: _____

Cell: _____

Signature: _____

Payment of any co-pays, coinsurance, or in the case of no insurance any other charges for services rendered, is due at the time of treatment and will be the responsibility of the adult bringing the child in for medical treatment.

This authorization will remain in effect until it is revoked by written notification.