PERMISSION TO TREAT A MINOR

I _____ give permission to my child_____
(Name of Guardian) (Name of child age 16-18 years)
_____ to attend his/her illness appointment alone without my presence and
(Date of Birth)
authorize treatment for my child in accordance with the office policy of Midwest Medical Specialists. This includes providing a history of present illness, disclosure of protected health information and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone if needed and to be financially responsible.

This authorization is effective on: _____ and expires_____.
(Today's Date) (Date Authorization is No Longer Valid)

A valid insurance card must be presented at the time of check-in for ALL appointments. Your child is expected to provide their insurance card if they are unaccompanied at their visit. If this is not feasible, please make arrangements with our office prior to the appointment.

Parent or Legal Guardian's Signature:_____ Date:_____

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