Consent for Treatment of a Minor Without Parent/Guardian Present

Patient Name: _____

Date of Birth: _____

I, _____, am the parent or legal guardian of the above-named minor. I hereby authorize **Multi-Care Medical** and its medical staff to provide medical treatment and services to my child without my presence during the appointment(s).

This authorization includes, but is not limited to, the following types of care:

- Evaluation and treatment by medical providers
- Physical examinations
- Ongoing treatment or therapy sessions as recommended.

I understand that:

- I will be informed of the findings, diagnosis, and any treatment plan as appropriate.
- This consent will remain in effect until I revoke it in writing.
- I may contact the office at any time with questions regarding my child's care.
- The provider may require my presence for certain types of visits or procedures.

Parent/Guardian Name (Printed): _____

Relationship to Minor: _____

Parent/Guardian Signature: _____ **Date:** _____

Phone Number: _____

Witness: _____ Date: _____

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