AUTHORIZATION FOR TREATMENT OF MINOR CHILD

NAME OF CHILD:_____

CHILD'S DATE OF BIRTH:_____

NAME OF CONSENTING PARENT/LEGAL GUARDIAN:_____

Parent or legal guardian consent must be provided for treatment of a child (minor patient under the age of 18). We understand there are times that it may not be possible for you to accompany your child to a visit and it may be more convenient to have prior authorization for delivery of care to your child without a parent or legal guardian being present. Therefore, the clinicians in this office will accept the below authorization to treat your child for any visit. If you wish to authorize treatment to your child when another adult is accompanying your child to a visit, this authorization must specify the name(s) of the adult(s) over the age of 18 authorized to obtain treatment for your child.

Special note for divorced/separated parents: If both parents are involved in parenting the minor patient, each parent must authorize the other to obtain treatment for the child.

I give Tranquility and its clinicians authorization for the following adult(s) to obtain treatment for my child:

_____ _____
Name of Adult Relationship to Child

_____ _____
Name of Adult Relationship to Child

_____ _____
Name of Adult Relationship to Child

Since the adult(s) named above are involved in my child's health care, I further authorize that the clinicians can give and discuss with the adult(s) protected health information (PHI) about my child and understand that the adult(s) listed above will be responsible for conveying any such PHI to me.

To revoke this authorization, please notify the office in writing.

_____ _____
Signature of Parent/Guardian Date