OLE HEALTH

Patient Label

AUTHORIZATION TO TREAT A MINOR

Patient Name: _____ DOB: _____

I, _____, give the adult(s) (≥ 18 years of age) named below permission to accompany my child to his/her appointment and to provide treatment consent, as needed.

This adult is authorized to provide a history of my child's present illness, disclose and receive protected health Information relative to the appointment, consent to treatment needed, and witness any physical exam completed by the provider. This adult has a responsibility to relay any diagnosis, treatment plan, or prescription(s) to me.

1. Name: _____ Relation: _____
2. Name: _____ Relation: _____
3. Name: _____ Relation: _____

I agree to be available by phone to any of the phone numbers provided.

Primary Phone: _____ Secondary Phone: _____

ACKNOWLEDGEMENTS:

- I acknowledge that I will be financially responsible for any copays or costs accrued at my child's appointment.
- I acknowledge this adult may consent to a variety of medical and dental services, including dental sedation, restorative/extraction treatment, x-rays, medical examinations, lab work, vaccinations, and more.
- I acknowledge that it is the authorized adult's responsibility to inform me of my child's care and involve me in decision making, when possible.

This section applies to Medical and Psychiatric Services <u>ONLY</u>.
NOTE: Dental Services require an authorized adult to accompany all minors.

***For minors 16-17 years old (or who turn 16 years old after the completion of this form)**

By Checking this Box ☐ I, _____ give permission to my child to (Name of Parent/Guardian) attend to his/her appointment alone without my presence and authorize treatment for my child at OLE Health. This includes providing a history of present illness, disclosure of protected health information, and the Child's responsibility for relaying any diagnosis, treatment plan, or prescriptions to me.

*Administration of any immunizations or medical procedures will only be performed at the discretion of the primary medical care provider.

EXPIRATION: This authorization will remain in effect for one (1) year from the date signed unless a different date is specified here: _____ /_____ /_____

Parent or Legal Guardian Signature: _____ Date: _____