RELIANT MEDICAL GROUP
Part of Optum®

PLACE LABEL HERE

Name: _____

DOB: _____ Med. Rec. Site: _____

MR #: _____

00000129

MINOR

Permission to Authorize Routine Examination and Treatment of a Minor

☐ By checking this box, I revoke all previous *Permission to Authorize Routine Examination and Treatment of a Minor* forms.

Minor Child's Name: _____ Date of Birth: _____/_____/_____

I, _____ give permission to the adults below to go with my child to the Reliant Medical Group office without a parent/guardian. These adults can allow my child to have routine exams and treatment. This includes, but is not limited to, well visits and care for non-urgent medical problems.

Approved Adult(s):

Name: _____

Phone Number: ( ) _____ Relationship to Patient: _____

Name: _____

Phone Number: ( ) _____ Relationship to Patient: _____

Name: _____

Phone Number: ( ) _____ Relationship to Patient: _____

By checking this box, I am agreeing to let my child receive:

☐ Routine care and treatment <u>with</u> an approved adult present

☐ Routine care and treatment <u>without</u> a parent/guardian or approved adult present

☐ A vaccine with permission from the approved adult present

NOT EFFECTIVE UNLESS SIGNED AND DATED

Signature of Parent/Guardian: _____ Date: _____/_____/_____

Office Use Only:

Administrative: Consent Forms: Consent for Treatment MRN: _____