

# Medical Consent Form for Minors

## Patient information

Name of minor: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

## Parent/legal guardian information

Name of parent/legal guardian: \_\_\_\_\_ Relationship to minor: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

## Consent for Medical Treatment

I, \_\_\_\_\_, as the parent/legal guardian of \_\_\_\_\_, hereby give my consent for \_\_\_\_\_ to be provided by \_\_\_\_\_.

I understand that healthcare services may include but are not limited to, medical examination, diagnostic tests, medication, and/or surgery and that such services may be deemed necessary by the healthcare provider.

I acknowledge that the healthcare provider has explained the potential risks and benefits of the treatment options and has had the opportunity to ask questions and clarify any concerns.

I understand that I have the right to ask for additional information about the proposed treatment, to refuse treatment, or to seek a second opinion.

I authorize the healthcare provider and their staff to provide medical treatment to my child, and I assume full responsibility for payment for such treatment.

I hereby authorize the release of any medical information necessary to process insurance claims or for any other legitimate purpose.

In case of an emergency, I can be contacted at the following numbers:

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

I hereby certify that I am the parent/legal guardian of the above-named minor and that I have the authority to give the consent as outlined above.

Parent/legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare provider signature: \_\_\_\_\_ Date: \_\_\_\_\_