Alliance HEALTH

DATE: _____

M.R.N.: _____

PATIENT NAME: _____

PERMISSION TO CONSENT FOR MEDICAL CARE TO MINOR CHILD OR INCAPACITATED ADULT

The parent(s) of legal guardian of the following minor child or incapacitated adult:

HIPAA requires a seprate form for each patient

Name of Patient	Medical Record Number	Date of Birth	Insurance Type and Number	Medications / Medical Concerns / Allergies

Please bring the patient's insurance card to the visit

Authorize:

A primary person and an alternate are recommended

Name of authorized person	Address	Telephone
_____ Primary	_____	_____
_____ Alternate	_____	_____

to consent to any x-ray, examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care to be rendered to the patient on the advice of any physician, surgeon, dentist of other health care professional licensed to practice medicine, surgery, or dentistry.

This authorization shall be effective from the date signed through _____-_____, 20___, which must not exceed six (6) months from the date signed.

Signatures:

The signature and consent of one parent is sufficient – both may sign.
Guardian: please attach copy of Letters of Guardianship

_____ _____
Parent/Guardian Date

_____
Print Name Telephone (_____) _____

_____ _____
Parent/Guardian Date

_____
Print Name Telephone (_____) _____

Witness and notary are not required.