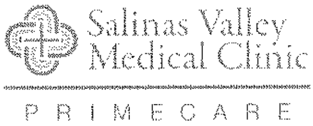

CONSENT TO TREAT A MINOR

Patient Name: ____ DOB: ___________________

The authorization below is effective for medical providers at Salinas Valley Medical Clinic - PrimeCare. With this authorization, I, the undersigned parent or legal guardian, authorize and consent to treatment rendered to my child, named above, in my absence.

This authorization allows the provider to act in my child's best interest, to diagnose, treat, and/or admit to a local hospital, which this attending physician may exercise his/her best judgment and deem advisable for continuing primary care or in an emergent situation. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care.

I agree to be financially responsible for all services rendered. I agree to make payment in full above and beyond the payment made by my insurance company. I also agree to financial responsibility for any treatment, per the written agreement as stated above and signed below.

Signature of Parent or Guardian: ____

Patient Name: ____ DOB: ___________________

It is against the policy of this practice to treat a minor child without the express written permission of the parent or guardian.