ALPENGLOW
WOMEN'S HEALTH

Minor Consent to Treat

I, *(parent / legal guardian)* ______________________________ , am unable to accompany my child

(child's name) ______________________________ , to Alpenglow Women's Health for his/her appointment.

Therefore, I give permission as follows ***(check one or both)*:**

◯ I give permission for *(adult's name)* ______________________________ , to accompany my child to seek treatment by any means necessary and provide consent for such treatment in my absence.

◯ I give permission for *(child's name)* ______________________________ , to seek medical treatment without being accompanied by a parent, guardian, or other authorized adult. (Must be 16 years or older)

Patient Name ______________________ Date of Birth ______________________

Allergies ____

Insurance Carrier ______________________ Policy Number ______________________

I agree to be financially responsible for the cost of any medical care provided to my child under this Authorization.

X ______________________________
(Print Name of Parent / Legal Guardian)

X ______________________________
(Signature of Parent / Legal Guardian)

X ______________________________
(Witness Signature)

X ______________________________
(Date)

X ______________________________
(Date)

Expiration of Permission

This form is valid only during the following time-frame *(cannot exceed one year)*

Effective Date ______________________ Expiration Date ______________________