CATAWBA VALLEY MEDICAL GROUP-AUTHORIZATION FOR TREATMENT TO MINOR

Minor's Last Name	Minor's First Name
Date of Birth	Account Number
Parent's Name(s)	Legal Guardian, if not the parent

I, _____, the natural parent/legal guardian of _____ grant the individuals listed below ("Authorized Individuals") permission to arrange for and authorize routine and emergency treatment at Catawba Valley Medical Group. I acknowledge that these authorized individuals are 18 years of age or older and that I have entrusted the care of my minor child to this person. This authorization includes permission for my minor child to receive scheduled immunizations. However, I understand that a parent or legal guardian must attend my minor child's first visit at Catawba Valley Medical Group. I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered for my child. I further understand that the authorized individual should bring any insurance information that is required at the time of service.

Authorized Individuals

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

I acknowledge that this consent shall remain in effect until revoked. I understand that I can revoke or change the approved individuals at any time and this document will not be applicable if the child is legally able to consent to treatment for him or herself.

I understand that this authorization does not include permission for the individuals listed above to obtain medical information regarding my child outside of the visit for which the child is being brought and does not include permission for the individual to obtain medical records.

I also give permission for the above named minor, if 16 years of age or older, to receive medical care without a parent/guardian or authorized individual being present. ☐ Yes ☐No

Signature-Parent or Legal Guardian	Date
Witness	Date