Minor Consent Form

Patient name: ______________________________ Date of Birth: _______________________

Who has the consent to authorize medical information for this child?

Name: ____________________________________ Phone: ________________________________
Relationship: _______________________________ Date Approved: ____________________

Name: ____________________________________ Phone: ________________________________
Relationship: _______________________________ Date Approved: ____________________

Name: ____________________________________ Phone: ________________________________
Relationship: _______________________________ Date Approved: ____________________

Name: ____________________________________ Phone: ________________________________
Relationship: _______________________________ Date Approved: ____________________

Authorization and consent of parent(s) or Legal Guardian(s). I hereby consent any information for my child above to be released to the signed individuals. I authorize him/her to have a copy of my child's medical diagnosis, prescriptions, invoices etc. I understand I am granting my authorization for the designated adult to obtain any information needed on my child.

Parent/Legal Guardian Signature:
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