Virginia Physicians, Inc.

Consent to Treat a Minor Patient Without Parent/Legal Guardian Present

Minor's Name: _____ DOB: _____

For the occasions when you may not be with your child, **please list those individuals who may give us consent to see your child:**

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

LIMITATIONS:
Identify any specific limitations on the kinds of medical services for which this authorization is gien. (If none, state "none")

☐ Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult**. This consent may only apply to minors **age 16 and older**.

This consent shall be in effect for: ☐ Date _____(only)

☐ Indefinitely, unless revoked by written comunication

AUTHORIZATION:
I (parent/legal guardian name) _____ request and authorize Cold Harbor Family Medicine and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Cold Habor Family Medicine and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interevntions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work.
I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____ _____
Parent or Legal Guardian Name (Please print) Relationship to Patient

_____ _____
Parent or Legal Guardian Signature Date