BOSTON MOUNTAIN RURAL HEALTH CENTER, INC.

Minor Consent to Treat & Authorization to Treat Minor Child Without Parent or Guardian Present

Patient's First Name	***Patient's Last Name***	***Date of Birth***
Parent or Guardian's First Name	***Parent or Guardian's Last Name***	***Relationship to Patient***

I hereby authorize Boston Mountain Rural Health Center to render the below marked services for treatment for _____, a minor, for whom I am legally responsible. I am fully aware that by signing this authorization, I am giving Boston Mountain Rural Health Center permission to render care associated with my child's treatment.

_____(Initial) I authorize BMRHC to render MEDICAL services.
_____(Initial) I authorize BMRHC to render DENTAL services.
_____(Initial) I authorize BMRHC to render BEHAVIORAL HEALTH services.

Our center requires that a parent or guardian give specific permission if a minor child will receive treatment when the child is accompanied by someone other than the parent or guardian, or if the child presents by himself or herself. When a parent or legal guardian is not immediately available and advanced consent has not been provided, emergency care will not be delayed, but verbal consent and authorization will be required as quickly as possible for treatment. Parental authorization is given below so that your minor child may receive treatment without his or her parent or guardian being present.

Minor Accompanied by Other than Parent or Guardian:

_____ (Initial) The person(s) listed here is/are authorized by me to give consent in person for medical or dental care for my child. This is in effect until revoked in writing by me. This person may also sign any necessary consents or acknowledgements on my behalf, including responsibility for payment.

Name: _____
Relationship to Patient: _____ **Phone Number:** _____

Name: _____
Relationship to Patient: _____ **Phone Number:** _____

I, _____(parent/guardian) grant permission for school personnel to transport and/or accompany the above named student to BMRHC visits. _____
(Name of Child's School)

As with other health related matters, health information cannot be released without consent.
I, _____(parent/guardian), therefore also hereby authorize BMRHC to release sports physical results to my child's school**.**

<u>Unaccompanied Minor Without An Adult Present: (PLEASE READ CLOSELY)</u>

I, _____ (parent/guardian) authorize that my minor child, whom I feel is of sufficient intelligence and listed above as the patient, may present unaccompanied by an adult and receive treatment of care. My child is authorized by me to give consent for medical or dental care. BMRHC staff will attempt to contact parent to discuss consent to perform procedures, including labs, immunizations and x-rays, however is the parent is unreached, the minor may also act on my behalf to sign appropriate consents forms for services rendered. **This is in effect until revoked in writing by me.** My child may also sign any necessary consents or acknowledgements on my behalf, including responsibility for payment. I understand that it is my responsibility ***Ultimately, it is up to the BMRHC provider's discretion to provide care to an unaccompanied minor depending that they feel that the child is of sufficient intelligence to understand and appreciate the consequences of treatment and procedures.***

Parent/Legal Guardian Signature: **Date:**

Implemented: 4/18