FAMILY MEDICAL CENTERS

CONSENT FORM
For Treatment of Minors in Parent/Legal Guardian Absence

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Medical Center: _____ **Gender:** _____

To comply with Ohio Law, the Family Medical Centers require that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) consent to the care of minor children. In the event that a parent or legal guardian is unable to consent to care, the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent medical/mental health treatment/dental appointment without a parent or legal guardian or a signed consent, treatment may be denied.

I/We (Parent's/Legal Guardian's Name) _____ ***authorize***

Appointee's Name: _____

Relationship To Patient: _____

Appointee's Address: _____

Appointee's Phone #: _____

to consent to - (check all that apply):

- ☐ *Emergent or Urgent Care at Family Medical Centers when I cannot be reached to include mental health treatment.*
- ☐ *Medical, Mental Health Treatment and Dental Care at Family Medical Centers including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia, except for a local anesthetic.*
- ☐ *Any and all necessary Medical /Mental Health Treatment/Dental and Surgical Care and Treatment at Family Medical Centers.*

for my child:

(Patient's Name) _____

during the period (not to exceed a maximum of 1 year):

- ☐ *Date (month/day/year)* From: _____ To: _____
- ☐ *For a maximum period of one year*
- ☐ *Family Medical Centers' providers should attempt to contact me before providing care at the following numbers:*

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

I further agree to reimburse the Family Medical Centers' health care providers for the cost of rendering these services to the extent that the minor's insurance does not pay for these services.

_____ _____

Patient Signature (Person Authorized to Consent for Patient) **(Relationship)**

_____ _____ _____

Child's Parent/Legal Guardian Address **Parent/Legal Guardian Phone Number** **Signature Date**

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