Allergy & Asthma

DIAGNOSTIC OFFICE

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CONSENT FORM to AUTHORIZE INDIVIDUAL FOR PATIENT (s) UNDER 18 YEARS and

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS WITHOUT PARENTAL PRESENCE

Name of Minor (s)	Date of Birth	Identify Allergies/Special Conditions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I/We, being the parent(s) or legal guardian (s) of the above minor (s), do hereby give my/our permission for medical treatment without my/our presence. I give my permission for _____
PRINT NAME

who is _____ to give authorization for all health care decisions for my
Relationship to Patient

child(ren) listed above. This permission is in effect for one year (365 days) from the date below unless revoked in writing. I understand that I, the parent/guardian am responsible for all payment due for date of services rendered.

_____ _____ _____
Parent/Guardian Name PRINTED Parent/Guardian Signature Date

_____ _____
Address Phone Number

Witness
Signature: _____ Date: _____

Insurance Company Information: _____

*Except in a true emergency, care may be ordinarily rendered to a child only with the consent of the parent or legal guardian. Sometimes a child many need care which is not, however a true emergency. In such cases, making an effort to contact a parent/guardian for permission can delay treatment and create unnecessary anxious moments.

According to New York State law, a minor may seek treatment for certain conditions without the knowledge or consent of his/her parents. In alcohol or drug abuse cases, venereal disease or certain other contagious disease, pregnancy, or family planning, only the minor may have access to the medical records unless he/she specifically gives consent for his/her parents or guardian to obtain the information.

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