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## PERMISSION TO TREAT A MINOR

I _____ give permission to my child _____
(Name of guardian) (Name of child age 16-18 years)

to attend his/her illness appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Bridlewood Family Healthcare. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance. This authorization is effective on: _____ and expires _____.
(Today's Date) (Date Authorization is No Longer Valid)

### Child's Health Information

Current prescribed or over-the-counter medications and dosages:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Allergies, illnesses or other comments: _____

_____

_____

### Emergency Contact Information for Parents/Guardians:

Where/how can you be contacted in case of emergency? _____

Phone: _____

Comments: _____

_____

### Temporary Guardian Information

Name: _____ Phone: _____

Address: _____

**Health Insurance Information** ☐ No change since last visit *(skip to next section)*

Insurance Company:_____ Policy Holder: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Copay: _____

**Parent or Legal Guardian's Signature**: _____ Date:_____