Foot & Ankle Centers

Authorization to treat minor

Authorization for treatment of minor by delegated person

Please fill this form out if anyone besides a parent or legal guardian will be accompanying minor to any future appointments.

Patient (minor) Name _____ Patient (minor) date of birth _____

I hereby authorize the following person(s) with my permission to seek medical treatment and sign for consent of treatment (*) of the named minor child in my absence and his/her protected health information (**) may be shared.

Name_____ Relationship to patient_____ Ph#:_____

Name_____ Relationship to patient_____ Ph#:_____

It is **my** responsibility to **notify** Centers for Foot and Ankle Surgery, Ltd. dba/ Foot & Ankle Centers, of changes and to complete new form.

*Medical Treatment includes exam, procedures, injections, radiology.
**Protected Health Information includes but is not limited to test results, diagnosis, treatment, and billing information. Highly Confidential Information will not be released unless the parent/legal guardian has also completed an Authorization for Release of confidential information form. This information includes mental illness, or developmental disability, psychotherapy notes, HIV, or AIDS testing or treatment (including information regarding test ordering, performance, or results, regardless of if the results were positive or negative), sexually transmitted disease, substance abuse, abuse of an adult with a disability, sexual assault, child abuse or neglect, genetic testing.

I certify I am the parent and/or legal guardian, I consent to the examination and/or treatment of my child.

_____ _____
SIGNATURE of Patient or Legal Guardian Date

_____ _____
Patient's Name (please PRINT) *PRINT name of Legal Guardian*