IU Health Physicians

Authorization for Consent to Treat a Minor

(PLEASE PRINT)

Name of Minor: _____ Date of Birth ____ / ____ /____
(First Name, Middle Initial, Last Name) *(mm)* *(dd)* *(yyyy)*

I, _____, as the Parent/Legal
(Printed Full Name of Parent of Legal Guardian)
Guardian of the above-named minor, do hereby authorize: ***(CHECK ONE)***

☐ Minor named above to be seen on his/her own behalf.

~ OR ~

☐ Designated Individual(s) listed below *(must be 18 years of age or older)* to give consent for the above-named minor:

(Printed Full Name of Individual Authorized to Consent)	*(Relationship)*	*Contact Phone Number*
(Printed Full Name of Individual Authorized to Consent)	*(Relationship)*	*Contact Phone Number*
(Printed Full Name of Individual Authorized to Consent)	*(Relationship)*	*Contact Phone Number*

for the following Medical Treatments: ***(CHECK ONE)***

☐ All surgical and medical treatment deemed necessary by the provider

~ OR ~

☐ Only the surgical and/or medical treatment deemed necessary by the provider for the condition or symptoms listed below: ***(SPECIFY CONDITION OR SYMPTOMS)***

_____

_____

_____

This authorization shall be limited to the following time period: _____ to _____ . If no time period is designated, this authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

Signature _____ Date _____
(Must Be Signed by Parent or Legal Guardian)

*VERBAL CONSENT WITNESSED BY (Two **IUHP** Associate/Provider Witnesses Are Required)*

Signature _____ Date _____
(Witness # 1 (IUHP Associate / Provider)

Signature _____ Date _____
(Witness # 2 (IUHP Associate / Provider)