

MRN: _____



CONSENT TO TREAT UNACCOMPANIED MINOR

This form is to be completed by a parent or legal guardian on behalf of each minor and filed in the minor’s chart prior to treatment of the minor. This form shall be (i) signed at the HonorHealth Medical Group office or (ii) signed, notarized, and returned to the HonorHealth Medical Group office prior to the minor’s appointment.

I, _____(name), parent or legal guardian of _____(name), a minor, born _____ (date of birth), hereby authorize HonorHealth Medical Group to provide routine medical care and treatment on behalf of said minor, which shall include but is not limited to examination, x-ray, and filling of prescriptions, from appropriate health care providers and clinic personnel. I authorize release of medical information necessary to process insurance claims concerning said minor. I authorize payment of medical benefits for medical care rendered to said minor. I understand I am financially responsible for any amounts not covered by my health insurance.

I DO NOT authorize HonorHealth Medical Group to do any of the following:

In case of an emergency, the parent or legal guardian should be contacted at the following:

Name:

Relationship to Child:

Address:

Phone Number:

Alternate Phone Number:

MRN: _____

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I agree that this consent is given freely and with certain knowledge of its purpose, in order to provide medical care and treatment for said minor. This consent shall remain effective until _____ (date), unless sooner revoked in writing and delivered to HonorHealth Medical Group.

ACKNOWLEDGEMENT

Parent or Legal Guardian Signature

Date

NOTARY ACKNOWLEDGMENT

STATE OF ARIZONA

COUNTY OF _____

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20_____,
by _____ (name of signer).

Notary Public Signature

My Commission Expires: _____

(Seal)

