BRONSON

Affix Patient Label

Name_____ Date of Birth_____

BRONSON PHYSICIAN PRACTICES

Pediatric Consent to Treat

We or I_____, the parent(s) or guardian(s) or power of attorney of_____give Bronson Medical Group Practices and its employees the right to treat my son or daughter or legal ward.

STATEMENT BY PARENT OR GUARDIAN AUTHORIZING AN ADULT OTHER THAN THEMSELVES TO OBTAIN TREATMENT FOR A MINOR CHILD

I hearby authorize the ADULTS NAMED BELOW* (must be 18 years of age or older) to secure medical treatment necessary for the welfare of my child.

_____
PATIENT NAME

1._____
Authorized person phone number

2._____
Authorized person phone number

3._____
Authorized person phone number

_____
LEGAL GUARDIAN/PARENT SIGNATURE DATE

IF YOUR CHILD IS OVER 16 YEARS OF AGE:

DO YOU AUTHORIZE THE CHILD LISTED ABOVE TO ATTEND OFFICE SERVICES BY HIMSELF/HERSELF?

YES **NO**

OUR OFFICE SHOULD BE MADE AWARE OF ANY SPECIAL CUSTODIAL RELATIONSHIPS. IF APPLICABLE, PLEASE EXPLAIN INT HE SPACE BELOW. DOCUMENTATION MAY BE REQUIRED.

(Example: parents are divorced but only one parent has guardianship, etc)

_____

_____

_____

_____

This authorization will remain in effect until revoked in writing by the above listed patient.