COURI CENTER

for Gynecology and Integrative Women's Health

Care of Unaccompanied Minor: Consent to Treat

Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child. Please note that patients 18 years of age and older do not require formal authorization.

AUTHORIZATION

I have the legal right to preauthorize this facility to deliver medical treatment to my child. I request and authorize Couri Center for Gynecology and its personnel to deliver medical care to my child, named below.

NAME

_____

Date of Birth _____

If *emergent* medical care is needed, first try to contact me regarding the medical situation of my child at the following telephone numbers. If you are unable for any reason to contact me, then you may rely on the designated decision maker's (physician, nurse practitioner, nurse) medical judgement.

Parent's Name

_____

Phone

_____

This consent remains in effect until I revoke it in writing, or until my child reaches the age of 18.

Signature of custodial parent or legal guardian:

_____

Date: _____