Great Lakes Chiropractic of St. Michael
116 Central Ave East St. Michael, MN 55376
PH: 763-515-6650 | FAX: 763-777-9186

AUTHORIZATION TO CONSENT TO TREATMENT

Dear Parent(s): State law requires that you consent to most medical treatments for your minor child. If an adult other than your child's parent or legal guardian accompanies him/her to office visits or your child is of legal driving age and will be coming to appointments without you, we will be unable to provide treatment without your written authorization, except in emergency situations. To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child or for your child to attend visits without you, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

PART I. AUTHORIZATION

I, _____ authorize the following individual(s)
Printed Name of Parent or Legal Guardian

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child(ren) listed below:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

AND / OR

I, _____ authorize my minor child of legal driving age to attend appointments on their
Printed Name of Parent or Legal Guardian

own. Consent for care is still required by a legal guardian.

PART II. LIMITATION

If time limitations are not specified below, authorization of this form will continue for one year.

_____

PART III. PARENTAL CONTACT INFORMATION

If the nature of the medical care is outside the initial reason for the appointment, we will attempt to contact a parent or legal guardian regarding the health care of the child listed at the following telephone number(s). If we are unable for any reason to contact a parent or legal guardian, we may rely on the delegate decision maker for consent.

Parent's Name: _____ Parent's Name: _____

Cell Phone: _____ Cell Phone: _____

PART IV. SIGNATURE

_____ _____
Signature of Parent or Legal Guardian Date