MID DAKOTA CLINIC
The doctors you know and trust.℠

AUTHORIZATION TO TREAT A MINOR

Parent/Legal Guardian Custodian: _____

Name of Minor Child: _____ DOB: _____

Relationship to Minor (check appropriate box):

☐ Parent ☐ Legal Guardian (attach court order) ☐ Foster Parent (attach proof, if any)

Date of Visit: _____ Reason for Visit: _____

I hereby give Mid Dakota Clinic, P.C., permission to provide medical care and treatment to the Minor Child, including labs and diagnostic imaging, without my presence.

The Minor Child may (check appropriate box): ☐ attend the appointment alone ☐ be accompanied by the following responsible adult: _____ (Name of Adult Accompanying Minor), _____ (Relationship to Minor), _____ (Phone Number).

This Authorization includes providing a history of present illness and disclosure of protected health information to the Minor Child and/or Accompanying Adult, who shall also have the responsibility for relaying any diagnosis, treatment plan, or prescription(s) to me.

I agree to be available by phone and to be financially responsible for all out-of-pocket expenses, including, but not limited to, copays, coinsurance and deductibles.

If the Minor Child needs a series of visits for the same Reason for Visit above, e.g., acne treatment, birth control, diabetes re-checks, etc., this Authorization will remain effective for the next 12 months, **if I initial here: _____.**

Emergency Contact Information for Parents/Legal Guardians/Custodians:

Where/how can you be contacted in case of emergency? _____

Phone: _____ Preferred Hospital (if any): _____

Child's Health Information:

Allergies, illnesses or other comments: _____

Health Insurance Information: ☐ No change since last visit *(skip to next section)*

Insurance Company: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Copay: _____

I swear under penalty of perjury that: I am authorized to make healthcare decisions for the above-named Minor Child; I give Mid Dakota Clinic, P.C. authority to examine and treat the Minor Child in the presence of, and to disclose the child's personal health information to, the Minor Child and/or Accompanying Adult according to the terms above; and that the information in this form is true and correct.

Signature: _____ Date: _____

County/State where signed: _____ County, State of _____