AUTHORIZATION FOR TREATMENT OF MY MINOR CHILD 14 YEARS OF AGE AND OLDER

Patient Name: _____ DOB: _____ Age: _____
(Last) (First) (M.I

Authorization of Other Caregivers

I, _____, hereby consent to Dirne Health Center, Inc ("Heritage") allowing the below caregiver(s) to make appointments for my child and bring my child to appointments at Heritage for the health care services authorized below. (*Initial all that apply*)

_____	_____	_____
Caregiver's Name	Relationship to Child	Phone Number
_____	_____	_____
Caregiver's Name	Relationship to Child	Phone Number
_____	_____	_____
Caregiver's Name	Relationship to Child	Phone Number

Authorization for Minor Child to Schedule and Attend Appointments Alone

_____ (*Parent Initials – do not initial if you **do not** want your child to attend appointments alone*) I authorize Heritage to allow my child to make appointments for and seek care for the services identified below without my knowledge or presence, and without the knowledge or presence of a caregiver identified above.

Consent to Services

I consent to Heritage providing the following health care services regardless of whether I am present (*Initial all that apply*):

____Preventative Care Services, including well checks, hearing screens, vision screens, screening labs, developmental screenings, mental health screenings.	____General Primary Care Services, including management of asthma, eczema and other similar conditions and evaluations for autism, learning disabilities, ADHD and other similar conditions.	____Medication Management, including prescribing and filling medication.
____Vaccines ____Contraceptive care services, including prescribing birth control, treatment of menstrual irregularities, and other similar care.	____Acute Illness, including cold and flu symptoms, sore throat, urinary tract infection, abdominal pain, and any other similar conditions.	____Testing for and treatment of sexually transmitted infections, including such testing and treatment for gonorrhea, chlamydia, herpes, and other similar infections.
____Substance Use Services, including treatment for smoking cessation, substance use counseling, and other similar services.	____Mental and Behavioral Health Services, including treatment for depression, anxiety, counseling, and other similar services.	____ Dental Services, including routine cleanings, fillings, x-rays, and other similar care.

____Other(s): _____

Acknowledgements

_____ (*Parent Initials*) If I have questions regarding any health care services consented to under this form, I will contact Heritage to address the questions. I understand that the practice of medicine is not an exact science and no promises or guarantees have been made nor can they be made to me concerning the outcome of the health care services. I understand if I have any questions regarding this authorization or about the services offered that I may discuss them with my child's health care provider.

By signing below, I acknowledge I have read and I understand the above. I declare that I am the minor child's biological parent, adoptive parent, or the individual granted exclusive right and authority over the welfare of a minor child under state law. I understand that I may revoke this consent at any time. except to the extent that services have already been rendered. To revoke this authorization, I further understand that I must provide written notice to Heritage. There are no penalties for revoking consent.

Parent's Full Legal Name (please print)	Signature	Effective Date
Witness' Full Legal Name (please print)	Signature	Effective Date

This form will expire one year from the Effective Date.