Authorization to Treat Minor Patient When Not Accompanied by a Parent or Legal Guardian

MetroHealth requires the consent of a parent or legal guardian to provide most types of care to minor patients. If you would like us to care for your child if brought in by another person or the child comes in alone (age 16 or older) please fill out and sign the authorization. This form is valid for five years from the date of signature.

I hereby provide permission for the following persons to bring my child _____ (please print minor patient's name) to The MetroHealth System. I give advanced authorization and consent to MetroHealth for my child to receive routine medical, dental, or other healthcare treatment (including diagnostic studies and interventions, prescheduled surgery) and for discussion of Protected Health Information (PHI) related to the care as considered necessary by the MetroHealth Clinic Staff.

If my child needs care beyond the original reason for the appointment/visit, an attempt will be made to reach me. I understand the accompanying adult will be allowed to consent to additional treatment if I cannot be reached.

Name Relationship to Patient

_____

_____

_____

_____

_____

Advance Authorization for Treatment of Minor 16 years and older ONLY:

Yes ☐ No ☐ Patient listed above is 16 years or older and may come alone and be treated unaccompanied by an adult for **scheduled** appointments. Financial and Insurance arrangements must be made prior to scheduled appointment or insurance on file will be billed.

Printed name of parent or guardian: _____

Signature of parent or guardian: _____

Date signed: _____

Parent telephone: _____