ob-gyn women's centre of Lakewood Ranch, LLC

MINOR CONSENT

Name of Child: _____

Child's Birth Date: _____

Name of consenting Parent/Legal Guardian: _____

AUTHORIZATION TO ALLOW PROVIDERS TO TREAT CHILD WHEN ACCOMPANIED BY BELOW LISTED ADULT(S)

Please be aware in signing this consent that you authorize the physician(s) to examine your daughter on this visit as well as future visits with or without you being present.

I give the office authorization to treat my child for any such treatment the providers determine is appropriate for my child, including but not limited to preventive care, physical exams, re-check, sick visit, diagnostic examination, immunizations and injections, sonogram, lab testing and any prescription of any medication deemed necessary when brought to the office by the following adult(s):

_____ _____

(Print name of adult) (Print relationship to child)

_____ _____

(Print name of adult) (Print relationship to child)

By law the physicians of this practice cannot release any information other than to the patient, unless a release of information sheet is signed by the patient to do so.

This authorization is in effect indefinitely from the date signed below unless revoked sooner.

_____

Parent of Legal Guardian Signature

_____

Witness

_____

Date