STONEBROOK
FAMILY MEDICINE

MEDICAL TREATMENT AUTHORIZATION FOR A MINOR

Office policy is; all minor(s) must have a parent/guardian whom has legal authority to make medical decisions concerning the welfare of the minor(s) seeking medical diagnosis and treatment, physically present in the office.

In the event a minor(s)'s parent/guardian cannot physically be in attendance, a signed consent must be obtained prior to any treatment of the minor(s).

**Note: Please ensure that all emergency contact demographics and methods are current with our office*

I,_____, herby give Mona Chacko, M.D., and employed licensed medical staff of
Parent/ Legal Guardian- please print

Stonebrook Family Medicine, authorization to render medical diagnosis and treatment for the following minor(s); up to and including the below outlined medical care.

Diagnosis and treatment may include:

- Obtain history and physical examination necessary to determine diagnosis and treatment plan.
- Ordering and administering therapeutic injections, laboratory; phlebotomy, urinalysis, culture, radiologic examination/radiograph, nebulizer treatment, EKG, in-office minor procedures (sutures, I&D, I&R, cryotherapy, cauterization) as necessary to the treatment and prognosis of the minor(s).
- Referral/transfer of protected health information and sensitive protected health information to another medical provider, specialist, pharmacy, EMT and medical insurance company as necessary to the medical decision making and treatment.
- In the event of an emergency (the parent(s)/guardian will be contacted immediately), please have the minor(s) included on this authorization transported to the below requested hospital emergency department.

_____

Name of Hospital | Phone No. | City | Zip Code

Minor(s) Authorized to Treat:

Patient's Full Name | Date of Birth

_____

_____

_____

_____

I understand this authorization does not have an expiration date and should I choose to relinquish the above authorization, I maintain the right to do so in writing via United States Postal Service, at which point this authorization will immediately expire upon receipt of the request for cancellation to treat a minor(s) listed in this authorization.

_____

Parent/ Legal Guardian - please print | Date

_____

Parent/ Legal Guardian- signature | Date

_____

Office Representative-Reviewed for Completion | Date

Please visit www.HHS.gov to learn about your individual rights as a patient and protected entity under the HIPPA-HITECH laws.

Last edit: 9/25/2017