Consent to Treat Unaccompanied Minor

The purpose of this form is to allow your child to come to Salud Pediatrics for a visit(s) without a parent or legal guardian. This form also allows the disclosure of information during visits.

Name of Child: _____ Today's Date: _____

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AUTHORIZATION

The above-named patient is authorized to visit Salud Pediatrics for their appointment without a parent or legal guardian.

I hereby authorize the protected health information to be exchanged between Salud Pediatrics and the above-named patient so that they may receive relevant information about their visit including discussions, topics and information relevant to the patient's visit.

ACKNOWLEDGEMENTS

I understand that sensitive information can be shared during the visit, including Mental Health, HIV/AIDS, Drug and Alcohol, Sexually Transmitted Disease, Pregnancy, and Birth Control.

I understand this form is valid until the patient turns 18 or is otherwise revoked. The revocation will not apply to information that has already been released in response to this authorization. I understand that I have the right to withdraw this authorization at any time by contacting Salud Pediatrics.

Print Name of Parent/Legal Guardian: _____

Signature of Parent or Legal Guardian: _____

Parent/Legal Guardian Telephone: (_____) _____-_____

Relationship to Patient: _____