HARDER family practice P.A.

2820 Ohio
Augusta, KS 67010
316-775-7500

CONSENT TO TREAT MINOR

Please complete a separate form for each child

This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and services provided at Harder Family Practice, PA.

I hereby appoint: _____ _____

Name Relationship to Patient

to make decisions, consent to, and authorize routine health care treatment and services for my child listed below.

I understand that treatment may include, but is not limited to, medical evaluation, physical exam, immunizations, x-rays, anesthetic, and lab work.

I hereby empower and grant the decision maker appointed above, permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below and to receive protected health information directly relevant to, and for purposes of, his or her involvement in the care or payment related to this care.

_____ _____

Child's Name Child's Date Of Birth

Parental contact information for questions regarding treatment:

_____ _____

Parent's Full Name Parent's Full Name

_____ _____

Parent's Daytime Phone Parent's Daytime Phone

_____ _____

Parent's Evening Phone Parent's Evening Phone

_____ _____

Parent's Mobile Phone Parent's Mobile Phone

I understand there is no obligation to contact me if the decision maker consents to the care of my child. The individual appointed as decision maker herein is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization shall remain effective until Harder Family Practice, PA receives written revocation, signed by the minor's Legal Guardian.

_____ _____

Signature of Parent or Legal Guardian Date