Trinity Health
IHA Medical Group

Medical Consent for a Minor

While it is strongly recommended that a parent/legal guardian accompany a minor patient to their visits, Trinity Health IHA Medical Group recognizes that occasionally this is not possible. The purpose of this form is to document a parent/legal guardian's written permission for another adult to accompany a minor to an office visit in the parent or legal guardian's absence and to consent to recommended medical treatment for the minor.

Provide the following information about the minor patient:

Minor Patient's Name	Birthdate	Address

Provide the following information about the adult(s) you authorized to bring your child(ren) to appointments in your absence:

Adult #1 **Name**_____ **Phone Number**_____ **Relation to child** _____	**Adult #2** **Name**_____ **Phone Number**_____ **Relation to child** _____
Adult #3 **Name**_____ **Phone Number**_____ **Relation to child** _____	**Adult #4** **Name**_____ **Phone Number**_____ **Relation to child** _____

State how long the authority and delegation will last and list any restrictions to delegation:

Check One:

☐ **Ongoing Delegation** starts on ____/_____/_____ and ends when minor turns 18 or when revoked in writing.

☐ **Temporary delegation** starts on ____/_____/_____ and ends on ____/_____/_____.

Restrictions placed on this delegation _____

(List any restrictions on the authority of the above-named Adult(s) to consent to treatment without your further consent)

**Annual Review of this document is required but new form not needed unless changes or updates.*

Signature from at least one Parent/Legal Guardian is required:

I/we understand this delegation authorizes Trinity Health IHA Medical Group to disclose my/our child's medical information to the above-named Adult(s) and to rely on their authority to consent to medical treatment. I/we understand that unless I/we have specifically restricted the above-named Adult(s) from this authority, the above-named Adult may consent to medical treatment for my/our child. I/we understand that if there are questions about this delegation, or the above-named Adult(s)'s authority, Trinity Health IHA Medical Group may decline to provide treatment to my/our child until I/we are present or otherwise provide adequate authorization. I/we understand that this delegation does not relieve me from financial responsibility for care and treatment provided to my child(ren).

Parent Printed Name _____ Phone: _____

Signature Parent/Legal Guardian _____Date: _____

Parent Printed Name _____ Phone: _____

Signature Parent/Legal Guardian _____Date: _____