Albemarle Center for Family Medicine

A Division of Anchor Healthcare, PLC.

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PARENTAL CONSENT FOR TREATMENT & CARE OF MINORS

I, ____________________________________, being the parent and/or legal Guardian of the minor age child, _______________________________, hereby give consent for medical treatment and care, up to and including emergency treatment, by the health care provider(s) affiliated with Albemarle Center for Family Medicine.

In the event that I am not available at the time this minor requires medical care, I give the party listed below the authority to seek and authorize care.

This consent will remain in effect until I sign a written revocation.

________________________ ________________
Signature of Parent/Legal Guardian Date

________________________ ________________
Witness Date

Alternate Parties Authorized to Seek Medical Care for Minor Child

1.__________________________________ ____________________________________
Printed Name Relationship

Work Phone:_______________ Home Phone:______________ Initial of Legal Guardian:________

1.__________________________________ ____________________________________
Printed Name Relationship

Work Phone:_______________ Home Phone:______________ Initial of Legal Guardian:________

Patient Name:______________________________ DOB:__________

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