Consent for Treatment of Minor Child

Patient's Name: _____ Date of Birth: _____

MRN: _____

I, _____, being the parent or legal guardian of minor patient listed above, realize there may be times when I may ask or need a family member or friend to bring my child to Coastal Carolina Health Care (CCHC) for healthcare services, even if I am not present. I authorize the following individuals to bring my child in to be seen and treated by CCHC providers in my absence.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IMPORTANT NOTE: I understand that this authorization does not include health care services which may require a parent or legal guardian to sign an informed consent. If I am unable to accompany my child for these services, I must provide specific written consent at EACH of these visits to authorize the person assisting in my child's healthcare.

Parent or Legal Guardian Signature: _____ Date: _____

Printed Parent's Name: _____

Printed Legal Guardian's Name: _____

CCHC's Representative Signature (Witness): _____ Date: _____