



CONSENT TO TREAT MINORS

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some point in time be unable to accompany your child. I hereby grant: **Heritage Urgent & Primary Care** permission to treat my child when they arrive to the office unaccompanied.

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Consent

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_