Patient Name: _____ Date of Birth: _____

NORTHWEST COLORADO HEALTH

Minor Consent for Treatment

We at Northwest Colorado Health feel it is also important for a parent of a minor child to attend all visits, but realize this may not be possible. This form may be used to allow an adult other than a parent to serve as a proxy/decision maker (delegate) for routine medical care and services at Northwest Colorado Health during follow up appointments. This form may also be used to grant permission to a minor child to be treated by Northwest Colorado Health without the presence of a parent, legal guardian or appointed proxy/decision maker. (Please note: A minor child may obtain Family Planning Services, including, among other services, contraception, STD testing, pre-natal and other pregnancy care, breast and pelvic examinations, behavioral health, or treatment for addiction or use of drugs or alcohol, without obtaining Parental permission.) Additionally, minors who are married may make health decisions without the permission of a parent or legal guardian.

If you would like to appoint a proxy decision maker, please review and complete the following form authorizing a proxy decision maker to consent to and authorize medical treatment or services for and to be involved in the care of a minor child. A proxy must be 18 years of age or older. You do not need to complete this form to appoint a legal guardian as a proxy.

AUTHORIZATION (Please check all that apply):

I/We as the parent/legal guardian(s) of minor child:

_____ _____

Minor's Name Date of Birth

give my/our consent for emergency and routine medical, dental, and behavioral health treatment per the judgement of the treating provider **regardless of who brings the patient to the clinic** (as long as they are at least 18 years of age).

Exception: list person(s) who may not bring minor in.

_____

Exception 1

_____

Exception 2

I (we) have the legal right to delegate such consent. I understand that protected health information may be shared with the proxy to facilitate informed decision making and hereby agree to the sharing of same.

LIMITATIONS

Please identify any specific limitation on the kinds of medical services for which this authorization is given.

☐ None ☐ Limitations:

_____

_____

_____

Please turn over

Patient Name: _____ Date of Birth: _____

PARENT IDENTIFICATION

Parental contact information for questions regarding treatment:

_____	_____	_____
Parent Name	Phone Number	Alternate Phone Number
_____	_____	_____
Parent Name	Phone Number	Alternate Phone Number

I (we) hereby indemnify and hold harmless Northwest Colorado Health, and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to Northwest Colorado Health. Only one parent's signature is required.

_____	_____
Signature of Parent or Legal Guardian	Date