Patient Name:	Date of Birth:	
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Staff Initials:

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, and breast and pelvic examinations, without obtaining Parental permission.)

If you would like to appoint a proxy decision maker, please review and complete the following form authorizing a proxy

child. A proxy must be 18 years of age or older. You do proxy.		
AUTHORIZATION (Please check all that apply):		
I/We as the parent/legal guardian(s) of minor child:		
Minor's Name ☐ hereby appoint the following person(s) as a proxy/de treatment and services for my child listed above:	Date of Birth ecision maker to consent to and aut	:horize routine health care
Proxy Printed Name	Relationship to Patient	
Proxy Printed Name	Relationship to Patient	
I (we) have the legal right to delegate such consent to the who is legally and medically competent to exercise the sinformation may be shared with the proxy to facilitate i same.	authority so delegated. I understan	d that protected health
☐ hereby grant permission for said minor child to receiproxy/decision maker.	ve medical treatment in the absenc	ce of parent, legal guardian, or
LIMITATIONS		
Please identify any specific limitation on the kinds of me	edical services for which this author	rization is given.
□ None □ Limitations:		
		Please turn over
Staff Initials:		Revision: May 2018

Patient Name:		Date of Birth:		
PARENT IDENTIFICATION				
Parental contact information for	questions regarding treatmen	t:		
Parent Name	Phone Number	Alternate Phone Number	-	
Parent Name	Phone Number	Alternate Phone Number	-	
attorneys, directors, insurers, aff liability for acting in reliance on t decisions or consent to the care delivered pursuant to this author	iliates, subsidiaries, related co his authorization. The individu in my absence. I also agree to rization. This authorization is v	o Health, and all their officers, agents, rporations, successors, heirs and assignal appointed as proxy (listed above) is accept financial responsibility for all called for one year (1) following the datestricted by time frame as noted above	gns from any and all spermitted to make are and services e signed below	
Signature of Parent or Legal Guardian		Date		

Staff Initials: _____ Revision: May 2018