ST. ANTHONY Clinic

Authorization to Treat a Minor

I, the undersigned, hereby authorize providers at St. Anthony Physician Clinics to provide medical treatment and/or surgical treatment to my child.

I further authorize the following people acting on my behalf to consent to such medical and/or surgical treatment as St. Anthony Physician Clinics' medical providers may deem medically necessary or advisable for my child.

Adult's Name:_____Relationship to Child:_____
(Print Name)

Adult's Name:_____Relationship to Child:_____
(Print Name)

Adult's Name:_____Relationship to Child:_____
(Print Name)

Adult's Name:_____Relationship to Child:_____
(Print Name)

This authorization shall remain in effect until _____.
(Date)

Information about the Child

Child's Full Name: _____Child's Date of Birth: _____

Signature/Authorization

Parent/Legal Guardian's Name: _____Date: _____
(Print Name)

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

Signature: _____ Date _____
(parent/legal guardian name)

Signature: _____ Date _____
(St. Anthony Clinic Employee)