AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS WHEN ACCOMPANIED BY NON-PARENT/LEGAL GUARDIAN

1. Patient Information	NAME _____ Office Use Only MRN _____ Date of Birth _____
2. Parent/Legal Guardian Information	Name _____ Relationship _____ Address _____ Home phone # _____ Work phone # _____
3. Designated Person To Act On Parent/Legal Guardian Behalf	Name _____ Relationship _____ Address _____ Home phone # _____ Work phone #

- This consent lasts for one year after the date a parent/legal guardian has signed unless a different expiration date is entered here: _____
- I understand that parent/guardian may revoke this consent at any time by notifying the providing organization in writing; and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- If the nature of the medical care is not routine, I understand that you will make every effort to notify parent/guardian of the situation and obtain parent/guardian consent for care. If such efforts to contact parent/guardian are unsuccessful or if the situation requires action without delay, I authorize the physicians and other personnel referenced above to take such action as is medically necessary on the minor's behalf.
  Minnesota, Wisconsin and North Dakota law have created specific exceptions to the general rule requiring parental or guardian consent for treatment of a minor. **PLEASE REFER TO POLICY EHA5010 FOR SPECIFIC STATE STATUTE EXCEPTIONS**

4. Signature of Parent/ Legal Guardian and Date	_____ Signature of Parent/Guardian Printed Name ☐ Parent of Minor ☐ Court-appointed guardian/conservator _____ Date
5. Verbal Authorization of Parent/Legal Guardian	Name of two witnesses for telephone authorization from Parent/Guardian _____ _____ _____ Date