Blackhawk Medical Group

Consent for the Care of a Minor Patient

PATIENT INFORMATION				
Child's Name (Last, First, Initial)			**DOB:**	**Gender:**
Home Address:			**City & State:**	**Zip:**
Patient's PCP:			**Home Phone #:**	**Cell Phone #:**

In addition to the custodial parents of the above child, the following people have my permission to bring my child to Blackhawk Medical Group and authorize recommended care for my child.

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____

Yes No It is OK to leave messages on my home or cell phone with results/personal health information.

Yes No It is OK to leave appointment reminders on my cell or home phone for the minor patient.

Yes No It is OK to disclose information about my child's care or treatment to any individual who states that they are a family member or friend.

Yes No It is OK to disclose information about my child's care or treatment only to the following family members or friends named:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

_____ DO NOT disclose information about my child's care or treatment to any individual, regardless of relationship or stated relationship.

I authorize the providers of Blackhawk Medical Group and their designees to care for the minor patient named above and for whom I am responsible. I certify that the information I have provided is true and correct.

Authorized person: (print name please) _____

Signature: _____ Date: _____

Relationship to Patient: _____ Phone: _____