MID-STATE HEALTH CENTER
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Plymouth, NH 03264
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midstatehealth.org

Authorization to Treat a Minor Child in Absence of a Parent/ Legal Guardian

Please check one of the following:

☐ The minor child under my legal care is 16-17 years of age, and I authorize him/her to attend an **unaccompanied** appointment. In addition, I give consent for medical care/ emergent care as described below.

☐ The minor child under my legal care is under 18 years of age, and I give my consent for him/her to attend an appointment **accompanied by an adult representative greater than 18 years of age** as designated below. In addition, I give consent for medical care as described below.

I/ We,_____, the parent or legal guardian of _____
(Name of both Parents or Legal Guardian) (Name of Minor Child)

With DOB: _____hereby authorize _____ to
(Name of Adult Bringing Child to the Office)

accompany my above-named child to office visits at Mid-State Health Center and consent to the examination and/or treatment of my child during the visit(s).

Medical Care:
The undersigned hereby authorizes Mid-State Health Center to provide ongoing medical treatment, by any clinician (including support staff) licensed through the State of New Hampshire and employed by Mid-State Health Center for my minor child when such treatment is deemed necessary by the physician in conjunction with the current injury/illness being treated by Mid-State Health Center. This care includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

Emergent Care (If Applicable):
In addition, I hereby authorize Mid-State Health Center, to provide emergent care by any licensed physician, physician assistant, or nurse practitioner, etc. (including support staff) for the above-mentioned minor if I cannot be reached within a reasonable amount of time, by reason of absence from the community or otherwise.

Such consent may include, but is not limited to medical treatment, test, X-ray examination, injections, immunizations or medication, and the performing of whatever procedures may be deemed necessary or advisable. It is understood that this authorization is given in advanced of any specific diagnosis, treatment, or hospitalization required, but is given to provide the authority to consent thereto as our said agent and the above-named child's attending clinician, in the exercises of his or her best judgment, may deem advisable.

This authorization:

- ☐ is effective only on _____/_____/_____.
- ☐ is effective from _____/_____/_____ to _____/_____/_____.
- ☐ is effective until revoked by me in writing.

_____ _____
Signature of Parent A or Legal Guardian Date

_____ _____
Signature of Parent B or Legal Guardian Date

Revised: 06/23/2021 rje/ ab/ eh