CORNERSTONE HEALTH

Medical ▪ Counseling ▪ Recovery

MINOR TREATMENT AUTHORIZATION AND CONSENT FORM

The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This "Minor Treatment Authorization and Consent Form" gives authority to Cornerstone Health Medical Clinic to provide care to the minor when the parent/legal guardian is not present. Revocation of this authorization must be submitted in writing.

Minor's Full Name _____ Minor's Date of Birth _____

Minor's Address _____ City _____ State _____ Zip _____

I give Cornerstone Medical Clinic authorization to treat my minor child as medically necessary without my presence.

Parent/Legal Guardian Signature _____ Date _____

Parent/Legal Guardian (please print) _____

Address of Parent/Legal Guardian _____ City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

Staff Signature & Date: _____

Revocation:

Parent/Legal Guardian (print, sign, date) _____