SPRINGFIELD CLINIC
*Leading the Way*

MRN or PATIENT LABEL

# AUTHORIZATION FOR TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

This will authorize Springfield Clinic Provider(s) (list all that apply)_____
_____, providers under his/her supervision, and any other providers covering for said provider(s) to provide medical care, including examination, treatment, x-ray examination, laboratory tests, local anesthetics, medical diagnosis and hospital care to _____, a minor (*DOB* _____). It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization in order to avoid delay in providing such treatment as is deemed necessary by the aforementioned doctor(s). This authorization to treat will remain in effect until said minor patient turns age 18, becomes emancipated, or until _____, 20____, unless revoked sooner in writing.

☐ This form authorizes said minor to present for minor care and treatment unaccompanied by an adult.

☐ This form authorizes said minor to present for minor care and treatment accompanied by an adult other than his/her parent or legal guardian. Those persons are named below. Please print name and relationship to patient.

_____
*Name* *Relationship*

_____
*Name* *Relationship*

_____
*Name* *Relationship*

_____ _____
*Date* *Signature of Parent/Legal Guardian/Person having legal custody*

_____
*Print name of Parent/Legal Guardian/Person having legal custody*

_____
*If signed by other than parent, indicate relationship.*

_____
*Daytime Phone Number*

_____ COPY TO PARENT OR LEGAL GUARDIAN

A facsimile of this authorization shall be considered valid as an original. NOTE: This authorization does not entitle the designee to have hard copy records, treatment follow-up, or to otherwise participate in the minor's care.