



**CONSENT FOR MEDICAL TREATMENT OF A MINOR BY
“A QUALIFIED ADULT RELATIVE”**

I hereby authorize Huntington Health Physicians offices to provide medical examination and treatment to:

Name of Minor: _____
(Please Print Clearly)

Date of Birth of Minor: _____

I hereby authorize (Name) _____ (Relationship) _____
to accompany my minor child to Huntington Health Physicians offices in my absence on
(date) _____.

I further authorize Huntington Health Physicians Offices to prescribe, order x-ray
and/or laboratory examinations, or other ancillary services deemed advisable.

Name of Parent or Legal Guardian
(Please Print Clearly)

Relationship

Signature

Date:

Telephone Number (Home)

Telephone Number (Cell)

** A qualified adult relative may grant consent if the minor lives with that adult. A ‘qualified adult relative’ is defined as an adult spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix “grand” or “great” or the spouse of any of those persons.*