Huntington
Health Physicians

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 Relationship

(Please Print Clearly)

_____ _____
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.*