



# Bent Tree Family Physicians

## Consent to Treat Minors & Authorization to Discuss Medical Information

**Authorization to Discuss Medical Information:** Bent Tree Family Physicians is committed to quality patient care and maintaining patient confidentiality. Our policy is to communicate only to patients and/or guardians personally or through our patient portal in regards to their confidential medical information. By completing the information below, you are allowing Bent Tree Family Physicians to communicate more detailed information to other individuals and/or your voicemail. **Please understand that this consent will remain effective until I notify Bent Tree Family Physicians in writing.**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Person-to-Person Communication:** I give permission to Bent Tree Family Physicians to verbally discuss information about my child's medical care with the following individual(s):

<b>Parent/Guardian:</b>	<b>Relationship:</b>	<b>Preferred Phone Number:</b>	<b>Permission for Detailed Voicemail:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Preferred Email Address:</b>			
<b>Please share:</b> <input type="checkbox"/> Scheduling Information <input type="checkbox"/> Medical Information <input type="checkbox"/> Billing Information			

<b>Parent/Guardian:</b>	<b>Relationship:</b>	<b>Preferred Phone Number:</b>	<b>Permission for Detailed Voicemail:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Preferred Email Address:</b>			
<b>Please share:</b> <input type="checkbox"/> Scheduling Information <input type="checkbox"/> Medical Information <input type="checkbox"/> Billing Information			

**Consent to Treat Minors:** Prior authorization is required by Bent Tree Family Physicians in order to treat a minor (a patient under the age of 18) without the presence of his/her parent or legal guardian. With this document you may appoint anyone who is over the age of 18 to accompany your child to their medical appointment. **Please understand that this consent will remain effective until I notify Bent Tree Family Physicians in writing.**

**In my absence, I authorize the following individual(s) to accompany my child:**

<b>Name:</b>	<b>Relationship:</b>	<b>Preferred Phone Number:</b>
<b>Name:</b>	<b>Relationship:</b>	<b>Preferred Phone Number:</b>

\_\_\_\_\_ Initial here if you wish to give consent for the minor to receive medical care without an accompanying adult. **This shall be in effect indefinitely, until revoked by written communication.**

Please be advised that we will not be able to perform any invasive procedures unless a parent or legal guardian is present. If such services need to be performed, another appointment will need to be scheduled for the procedure. It is a policy of this office that the adult accompanying the child or the child alone is responsible for the payment of the patient portion at the time of service.

**I have read the information above and understand that these consents will remain effective until I notify Bent Tree Family Physicians in writing.**

\_\_\_\_\_  
Parent/Legal Guardian (Print)

\_\_\_\_\_  
Signature Parent/Legal Guardian

\_\_\_\_\_  
Date

Revised: 9/27/17