Boulder Community Health
Ambulatory Services Department ***Clinic Name*:_____*Provider*:_____**

Parental Consent for Treatment

Minor Presenting Alone, or with an authorized Non-Parent/Guardian

I, _____ (parent/guardian), give permission to Boulder Community Health to treat my child, _____(child's name), DOB _____, in the event he/she presents to the clinic alone, or is accompanied by persons listed below. The persons listed below have my permission to make decisions regarding the care and treatment of the child listed above. I understand that any charges resulting from the visit will be my responsibility. The clinic has my permission to forward pertinent medical and other information from these visits to the insurance plan covering my child if applicable.

Please check one:

_____ This form is valid for one year from date of signature.

_____ This form is valid for the following dates: _____ to _____.

Names of additional people authorized to make decisions regarding the treatment of my child during routine office visits:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Name (please print):_____

If this is a verbal / phone authorization:
Signature of BCH staff receiving authorization, Signature of Witness to the verbal/phone authorization

_____
Date

_____ _____
Signature of BCH Staff Receiving Authorization Signature of Witness to Verbal/Phone Authorization