KODIAK COMMUNITY HEALTH CENTER

MRN #___________
1911 East Rezanof Dr
Kodiak, AK 99615
Phone: (907) 481-5000
Fax: (907) 481-5030

Consent to Treat Minor Patient without Parent or Legal Guardian Present

By completing and signing this form, I hereby consent to the medical treatment of the minor named below and represent that I have the legal authority to do so as the minor's parent or legal guardian, with the understanding that KCHC may ask me to provide written proof of such authority. I further consent to KCHC's treatment of the named minor:

Minor Patient Name: ______________________ Date of Birth:_________________

Name(s) of All Parent(s) and/or Legal Guardian(s) With Authority to Consent to Medical Treatment for Minor Patient: ____

Name of Parent or Legal Guardian Filling Out This Form: _________________________
Relationship to Minor: __________________________
If Sharing Custody of Minor with Other Parent – Do you have LEGAL custody of the minor? (Y/N) Phone #: ________________________

Consent form will be valid for one year or until withdrawn from the date of signature below, unless indicated expiration on the following date: ________________

AUTHORIZATION:

I (parent/legal guardian) ________________________________ authorize Kodiak Community Health Center and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware the patient/guardian will be financially responsible for any future bills received.
I have the legal right to preauthorize Kodiak Community Health Center and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to medical evaluation, physical exams, routine immunizations, lab work, wound treatment, etc.
I have read, understand, and give my consent as agreed above. My signature as the parent/legal guardian means that I have read this form and/or have had it read to me and explained in a language that I can understand.

____
Parent or Legal Guardian (print name) Relationship to Patient

____

Parent or Legal Guardian Signature **Date**

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Witness **Date**

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