Community Health Care, Inc.

MRN#_____

CONSENT FOR TREATMENT MINOR UNDER THE AGE OF 18

I, _____, allow the providers and employees of Community Health Care, Inc. (CHC) to assess and treat the needs of the minor, (Minors Name)_____. This includes anything needed to diagnose the minor, any shots, or any treatments ordered by CHC providers. While giving care or while doing any lab procedures, the parent/guardian and/or CHC Staff may need to hold the minor down. This could include use of the papoose board, holding the hands, upper body, head, and/or controlling leg movements.

I give my permission to release the minor's health/financial information that is needed to conduct audits and/ or process insurance claims including: HIV, mental health, STDs, genetic testing, and drug abuse. I also give permission for the payment of the claim for services be paid to CHC on behalf of the provider. I also ask for government benefits to be paid to CHC on behalf of the provider who accepts them.

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

Legal/ Biological/Adoptive parents are allowed to bring their children to appointments and obtain medical information about their children. To make these processes easier please list both parents:

Legal Parent #1/Biological/Adoptive/:_____
Legal Parent #2/Biological/Adoptive/:_____

I understand I should make every effort to accompany my child to appointments.

I will allow the following names listed below to consent for my child's treatment only.
It does not allow release of records, that will require a separate signed release of information.

NAME	Relationship	ALL	Scheduling/ Appointment	Office Visits	Billing	Papoose Board (Dental/Lab)	Prescriptions	HIV
		☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐

Specific Instructions or Limitations: _____

- I understand the minor may not be seen if they arrive at the clinic with a care giver who does not meet the above chosen guidelines.
- I understand that a written permission note signed by me will always be acceptable as consent for any services included in the note.

I give my consent to leave detailed information on voice messages and/or send detailed text messages regarding the minor. This may include lab results, test results, form/records information, and medication information. This **WILL NOT** include mental health, substance use, sexually transmitted diseases, genetic testing, and HIV information. We will need to speak to you directly about this type of information.
It is your responsibility to ensure we have your most current phone number on record.

Please mark your choice to participate in receiving detailed voice messages and text messages.	
☐ Yes, I consent	☐ No, I do not consent

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. I know that I need to update the consent form and notify CHC immediately if changes need to be made for demographic, insurance coverage, etc. This consent is valid until I tell CHC to cancel it

X_____

(Signature and Date)