

Designation of Another Person to Consent for Medical Care of a Minor

BASTYR CENTER | *the teaching clinic*
FOR NATURAL HEALTH | *of Bastyr University*

Patient Information

This form gives Bastyr Center legal permission to treat your child in case you cannot accompany him/her to the clinic for treatment. Consent may include, but is not limited to clinic visits, medical treatment, and tests.

❖ **A parent/legal guardian must attend a minor's first visit with Bastyr Center for Natural Health.**

Patient Name: _____ Date of Birth: ____ / ____ / ____

Parent/Legal Guardian Name: _____

I hereby authorize (*person's name*) _____
as a representative to give consent to any medical or surgical treatment by any licensed physician in the State of Washington for our child at the Bastyr Center for Natural Health.

or

{ } Please *initial here* if you are authorizing the minor to seek and consent to treatment with no adult present.

I acknowledge that we are responsible for all charges in connection with the care and treatment rendered.

Expiration of Permission (check one):

_____ This authorization shall remain effective until revocation in writing by the undersigned.

_____ This form is VALID ONLY during the following timeframe:

Effective date: _____ / Expiration Date: _____

In case of emergency, I can be reached at:

Phone number: (_____) _____

(SIGNATURE of parent/legal guardian)

(Today's Date)