Port Lavaca Clinic

Consent to Treatment of a Minor

Name of Minor: _____

Minor's Treatment: I am the parent/guardian, _____
Printed Name of Parent/Guardian

For the above named minor patient I authorize Port Lavaca Clinic's medical staff to provide medical/dental/vision, and/or emergency treatment to my child. I understand that this authorization is given in advance of any specific diagnosis or treatment. I, the parent/guardian am financially responsible to pay the cost of the services rendered to the child in accordance with the regular rate and terms of Port Lavaca Clinic. Family members (grandparents, aunt/uncles, cousins, adult siblings) and the following designated unrelated adults:

_____

_____

May bring the minor in for treatment at the Port Lavaca Clinic.

I understand that this form will be valid and remain in effect for one year from the date signed below. This form has been fully explained to me and I understand its contents.

_____ _____ _____

Signature Parent/Guardian | Relationship to Minor | Date