



### Consent for Treatment of Minor

**To the Parent or Guardian:** Legal considerations require us to obtain your consent to treat a minor child. *You must be a parent or legal guardian to be able to sign this form.* Be advised that by signing this form you are accepting financial responsibility for any and all visits this child may incur while this form is in effect. Please fill out and send completed form with your child or fax. Thank you.

- Grand River Primary Care    Fax 970.625.0725
- Grand River Specialty Care    Fax 970.625.0725
- Grand River Health Clinic West    Fax 970.285.6064

I hereby give permission for the providers and staff at Grand River Health to treat this child.

Childs Name: \_\_\_\_\_ Date: \_\_\_\_\_

Consent Given By: \_\_\_\_\_

Signature of Person Giving Consent: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Phone Number you can be reached during the day: \_\_\_\_\_

Providers being given permission to treat the child:

Specific provider \_\_\_\_\_

Any GRH Clinic provider \_\_\_\_\_

This form expires in one year from date of signature.

**Phone Confirmation** (FOR OFFICE USE ONLY)

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Consent Given By: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_