Pre-Authorization for Treatment of Minors

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 of Birth_____

Consent Given by: _____

Signature of Person Giving Consent: _____Date: _____

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 on _____ *

**This expiration date may be for 24 hours to cover one visit or it may extend up to 1 year. By signing this consent, you are authorizing the doctor to treat your child for any necessary care unless you specify in the area below.*
This consent is for _____ only.

Phone Confirmation (FOR OFFICE USE ONLY)

Child's Name: _____Date: _____

Reason for Visit: _____

Consent Given By: _____

Relationship to Patient: _____

Staff Signature: _____

Staff witness signature: _____

Comments: _____

_____