AUTHORIZATION TO TREAT A MINOR

Minor's Name: ____________________ Minor's Date of Birth: ____________________

Name of Parent or Legal Guardian: ____________________ Primary Contact Number: ____________________

MINORS:

A minor is defined under Iowa law as an individual under 18 years of age, not married, and not self-supporting.

Written authorization or permission from a parent or legal guardian is required to treat a minor if the parent or legal guardian cannot be present for the appointment. The authorization must be completed in person by the parent or legal guardian. If the written authorization is not received, a consent via telephone for current date of service will be accepted with appropriate verification. If appropriate authorization is not received the appointment is rescheduled until the appropriate permission is obtained and documented or parent/guardian is in attendance. The attending physician/provider may elect not to treat without parent/guardian present.

There are two exceptions to obtaining the parent or legal guardian's permission:

1. Minors may consent to treatment for birth control, other reproductive issues or drug or alcohol dependency. In these cases the parent or legal guardian may not be notified by the physician unless permission from the minor is obtained and documented in the patient's record.
2. Emancipated minors may consent to their own treatment. A minor is emancipated when the parents release him or her from their "care, custody, control, and service." The minor must be permanently living away from the parents' home, supporting him or herself and not receiving support from their parents. (Financial arrangements will be made prior to the appointment)

As the parent of legal guardian for the patient, I will allow the health care team(s) at Physicians' Clinic of Iowa to give the following treatment(s) to my child:

- ☐ Allergy / Audiology
- ☐ Ear, Nose & Throat
- ☐ Family Medicine
- ☐ General Surgery
- ☐ Hematology & Oncology
- ☐ Imaging
- ☐ Lab
- ☐ Neurology & Sleep Medicine
- ☐ Orthopaedics/Spine
- ☐ Osteoporosis & Bone Health
- ☐ Pediatrics
- ☐ Physical Medicine & Rehabilitation
- ☐ Plastic & Reconstructive Surgery
- ☐ Podiatry
- ☐ Rheumatology
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Walk-in Care

Written authorization: ____________ (staff initials) Phone authorization: __________/__________ (staff initials)

Treatment(s) (if applicable):

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I understand that:

- This consent applies only to the treatments listed above.
- This consent applies only when I am not present with my child to give consent to treatment.
- If I am with my child, I will decide whether to give consent to suggested treatment.
- This consent for treatment is valid for one year unless a shorter time frame is listed below

  Start Date: __________ End Date: __________ Telephone authorization is acceptable for one date only.

- I may revoke (take back) consent at any time by telling PCI in writing.

Person Authorized to Accompany Minor: ____________________ ☐ Minor may present self for care

This is to certify that I, the undersigned, consent to, and authorize the performance of all treatments and operations, and the administration of anesthetics, which in the judgement of the attending PCI provider, may be deemed necessary.

____ ____________________

Signature of Parent or Legal Guardian Date