KAISER PERMANENTE®

Colorado Permanente
Medical Group, P.C.

CONSENT TO AND DIRECTION FOR TREATMENT OF MINOR

To: Kaiser Permanente, physicians, nurses, and other health care providers.

Re: _____, a minor.

Date of Birth: _____Medical Record Number: _____

I (We), being the parent(s) or guardian(s), entitled to the care, custody, and control of the above said minor, do hereby authorize, request, and direct you and each of you to render such treatment to said minor, including diagnostic, medical and minor surgical care, as in your judgment is advisable. This consent to treatment is given in contemplation that the above minor may from time to time appear at Kaiser Permanente clinics, offices, facilities, and affiliated hospitals, for examinations or treatment or both, unaccompanied by an adult, or custodial parent, because of my (our) absence or unavailability.

I (We) understand that at times physicians, nurses, or administrators may deem it advisable that a parent or guardian or other authorized adult be present with said minor for the purpose of assisting in the diagnosis or treatment. I (We) agree to cooperate by being present with said minor at all times possible or when requested.

(For divorced or separated parents) As a custodial parent, I authorize the following individual(s) to consent to care for my minor child should I not be available to provide consent.

_____	_____
Name	Name
_____	_____
Relationship	Relationship

All aspects of this consent will be in effect until specifically terminated or modified by written notice received by the Medical Records Department of Kaiser Permanente at the medical office where the minor receives regular or continued medical care.

_____	_____
Signature	Signature
_____	_____
Relationship to Minor	Relationship to Minor
_____	_____
Date	Time

Note to parent or guardian: This form should be completed for each minor in the family and filed at the Kaiser Permanente medical office where you expect service to be rendered.