Cornerstone Clinic

Medical and Counseling Center

MINOR TREATMENT AUTHORIZATION AND CONSENT FORM

The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This "Minor Treatment Authorization and Consent Form" gives authority to Cornerstone Medical Clinic to provide care to the minor when the parent/legal guardian is not present. **Revocation of this authorization must be submitted in writing.**

Minor's Full Name Minor's Date of Birth

Minor's Address City State Zip

I give Cornerstone Medical Clinic authorization to treat my minor child as medically necessary without my presence. Treatment may be given by Byron Perkins, D.O., Triin Minton, M.D. Diana Hess ANP.

Parent/Legal Guardian Signature Date

Parent/Legal Guardian (please print)

Address of Parent/Legal Guardian City State Zip

Cell Phone Work Phone Home Phone

Staff Signature & Date: _____

Revocation:

_____

Parent/Legal Guardian (print, sign, date)

Affiliate of Christian Health Associates

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