

Authorization for Medical/Dental Care to Minors or Adults with Disabilities (Without Parent/Legal Guardian Present)

STATEMENT OF PURPOSE OF THIS FORM:

Families/legal guardians who are patients of Community Health Service Inc. (CHSI) are able to grant permission to CHSI to provide treatment(s) for preventative care, injury, illness that is non-life threatening and dental care for minors or for adults with disabilities. By completing this form it provides legal permission for CHSI to treat minor's ages of 14 to 17 years old or adults with disability without any parent/ legal guardian present.

Patient's Information:			
Name:	D.O.B:	I.D #:	
AUTHORIZATION:			
Parent/Legal Guardian's Name	Date of Birth		
I give authori for medical/dental care accompanied by the I am the legally responsible party:			
PERSON(S) AUTHORIZED TO ACCOMPAN	IY MINOR/ADULTS WITH DISABI	LITIES (Print Name)	
Name:	Relation to Minor/Adult		
Name:	Relation to Minor/Adult		
This authorization is valid for: ☐ Today'	s Visit: □ 1 Yea	ar, Renew on:	
Emergency Phone # 1:	Emergency Phone # 2:		
PARENT/GUARDIAN SIGNATURE: I understand that I am giving permission to that he/she presents to the clinic with one of the forward pertinent medical or other information understand there are certain procedures/pawill do its best to notify guardians of such procedures.	of the authorized individuals listed a prmation from this visit to the ins aperwork that will need a legal gua	above and I am granting permissio surance company, if applicable. ardian presence or signature. CHS	
Signature	Date	Date	
Staff Name (Print)	 Date	 Date	

- A parent / legal guardian MUST be present for a minor patient's first visit with CHSI

**** NOTE ****

- Vaccinations CANNOT be given without a parent/legal guardian present