South Lake Women's Health, P.C.

Consent for Treatment of a Minor

Date: _____ Time:_____

Patient's Name: _____

Patient's Date of Birth: _____

Name of Patient's Parent or Guardian:_____

Relationship to Patient:_____

1. I, _____, parent or guardian of _____, authorize and consent to examination, diagnostic testing, observation, non-invasive procedures or other medical treatment as considered necessary for the continuing care and treatment of _____, a minor.

2. I understand that this consent covers and includes future examination, diagnostic testing, observation, non-invasive procedures, or other medical treatment as considered necessary for the continuing care and treatment of _____, a minor, and that this authorization shall remain valid and in effect until the minor's eighteenth birthday or until this authorization is revoked in writing by me.

3. I certify that I have read and fully understand the aforementioned consent to treatment of a minor, and the explanations and therein referred to were made and that all blanks or statements requiring insertion or completion were filled in. I further certify that I am the above-named minor's legal parent or guardian with full authority to consent to medical treatment of the above-named minor.

_____
Signature of Parent or Guardian

_____
Signature of Witness