



## **CONSENT FOR NON-GUARDIAN TO BRING MINOR TO APPOINTMENT**

\_\_\_\_\_ Patient Name \_\_\_\_\_ Patient DOB

I am the parent or guardian of \_\_\_\_\_ (legal name of patient). I have the legal right to consent for medical treatment for this child (patient).

I authorize the following individual(s), who is a person(s) over 18 years of age and whose relationship to the child is:

_____	_____
Person bringing child to appt	Relation to patient
_____	_____
Person bringing child to appt	Relation to patient
_____	_____
Person bringing child to appt	Relation to patient

to bring the child to his or her medical appointment and to consent to medical care by the clinician(s) of Center for Emotional Health. I understand that this delegation includes receiving health information about the minor, necessary to make decisions for the patients medical/mental health care.

**\*\*\*\* This consent is valid for one year from the date on this form unless revoked sooner by me, the parent or legal guardian.**

**I understand by giving permission to the above named individuals to bring my child to the appointment and make medical decisions for my child that I am authorizing changes to be made to the medication regimen and dosages as I currently know it and I will not be involved in communication related to an appointment that the named individual attended on my behalf. I understand that to discuss further changes after this appointment I will be required to schedule an additional appointment.**

X \_\_\_\_\_  
Signature of Patient/Guardian

X \_\_\_\_\_  
Date