CONSENT TO TREAT MINOR PATIENT WITHOUT PARENT OR GUARDIAN PRESENT

I am the:

[ ] Parent
[ ] Guardian
[ ] Other person having legal custody: _____
(*specify legal relationship)*

of the following minor patient:

Full Name of Minor Patient: _____

Date of Birth of Minor Patient (MM/DD/YYYY): _____

I authorize One Medical to provide any X-ray examination, anesthetic, medical or surgical diagnosis or treatment for my minor child which is recommended by, and to be rendered under the general or special supervision of, any licensed healthcare provider when I am not physically or virtual present during the provision of such care.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or outpatient care being required, but is given to provide authority to One Medical to provide any and all such diagnosis, treatment, or outpatient care which a licensed healthcare provider at One Medical recommends for my minor child.

This authorization shall remain effective until the minor patient reaches the age of majority in their state of residence, unless sooner revoked in writing delivered to One Medical's Privacy Team (privacy@onemedical.com).

Date: _____

Print name: _____

Signature: _____

Last Edited: 18 February 2021_BS
Owner: Legal and Compliance Team