Hillside Family & Occupational Medicine, LLC

9220 Lake Otis Parkway, Suite 9 | Anchorage, Alaska 99507
Phone: (907) 344-0200 | Fax: (907) 344-0214

www.hillsidemedicine.com

Permission to Treat a Minor without a Parent/Guardian present

Hillside Family Medicine must receive permission from a child's parent or legal guardian before providing treatments for an injury or illness that is non-life threatening. This form gives us legal permission to treat your child in case you cannot accompany him/her to the clinic for treatment. If the party accompanying your child (baby-sitter, friend, relative, etc.) does not present this information the clinic will attempt to contact you to request permission to treat your child.

Please Note:

- **A parent/legal guardian must attend a minor's first visit here at Hillside Family Medicine.**
- **Minors may not receive immunizations without a parent or legal guardian present.**
- **This "Permission to Treat a Minor" form is valid only for the dates listed below with a maximum of 1 year.**
- **This "Permission to Treat a Minor" form allows Hillside Family Medicine to bill the insurance and/or the responsible party listed on the account for all charges in connection with the care and treatment rendered.**
- **In certain circumstances, in accordance with State and Federal laws, parent/guardian permission may not be needed for adolescents being seen for concerns of "heightened sensitivity" such as STD testing, family planning, mental health, etc.**

Patient Name: _____**Patient Date of Birth**: _____
(please complete the option below that best suits your request)

1. I grant _____ (an adult into whose care, the minor has been entrusted) to arrange for and authorize routine and emergency treatment at Hillside Family Medicine for the following dates: _____ (these dates indicate when this form is valid, max of 1 year).

2. We/I are authorizing the minor to seek and consent to treatment with no adult present. This authorization is for the following dates:_____
(Only valid for 1 date of service if not specified, max of 1 year.)

Please initial:
[___] We/I acknowledge that we are responsible for all reasonable charges in connection with the care and treatment rendered.

Signature: _____ **Date**: _____

Printed Name: _____

Relation to patient (documentation may be requested): _____

Please send the insurance card and co-pay (if applicable) to the appointment.

In case of Emergency, I can be reached at:

Home Phone: _____ Work Phone: _____ Cell Phone: _____