CONSENT TO TREAT A MINOR

I, _____ authorize Hoag affiliates and affiliated providers

to provide medical care for _____ born on _____
Patient Name Date of Birth

including immunizations, physical examinations, and testing/treatment for the purpose of medical diagnosis and treatment, which is deemed advisable by and is to be rendered by the providers and staff of Hoag affiliates and affiliated providers.

This authorization is effective as of _____.
Date

Parent/Legal Representative (Print Name): _____

Parent/Legal Representative Signature: _____ Date/Time: _____

Witness: _____ Date/Time: _____

Note: Minors 12 years and older may consent to medical diagnosis, or treatment of the following: infectious or communicable diseases which must be reported to the local health officer; sexually transmitted infection (STI), rape or HIV testing, mental health therapy or drug or alcohol related problems. Minors of any age may consent to medical diagnosis and/or treatment of the following: contraception, pregnancy, and diagnosis or treatment of sexual assault.