Atrium Health

Minor Consent to treat other than Parents

Minor's Name:

____________ ____________ __________ ____ __________

Last First Middle Sex Date of Birth

Father's Name: ____________________

Work #: ____________________ Cell #: ____________________

Mother's Name: ____________________

Work #: ____________________ Cell #: ____________________

As a parent/legal guardian, I understand I must give permission for my child to receive medical treatment. If possible, I will come with my child for every appointment at Piedmont Orthopedic Specialists. If I am unable to come with my child, I agree to let and give permission for any treatment. (Ex: grandparent, step parent, neighbor, etc.)

____________________(Name) ____________________(Relationship)

____________________(Name) ____________________(Relationship)

☐ Only mother and/or father will bring the child to appointments.

Child must be 18 years of age to be treated without a parent present, or to pick up a prescription

____________________ ____________________

Responsible Party Signature Date Patient Service Specialist Date

Effective for 1 year from date completed

Piedmont Orthopedic Specialists

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