VASCULAR & INTERVENTIONAL EXPERTS | iHealth Infinite Health Collaborative

Authorization to Consent to Treatment of a Minor

Minors 15 and under must have a parent/guardian in the clinic at all times.

I, _____, as the custodial parent/legal guardian of

_____ _____

(Patient Full Name) (Date of Birth)

authorize Vascular & Interventional Experts to provide health care services and treatment for the minor child named above. This authorization includes but is not limited to:

- ☐ Specialized care, assessment and treatment, as it relates to Vascular or Interventional Radiologic conditions.

Please check the appropriate box(es) below:

- ☐ This authorization is effective from the date signed until the treatment for this visit ends.
- ☐ This authorization is effective from the date signed until the plan of care ends for this course of treatment.
- ☐ I authorize the above minor (16 or older) to consent to treatment of care on their own behalf.
- ☐ I authorize the following individual(s), whom may accompany the minor to the clinic, to make treatment decisions on my behalf: (names of stepparents, grandparents, day care provider)

  _____

By providing verbal consent, I indicate that I am the above minor's legal guardian, fully informed, and understand the meaning of this authorization. This authorization may be removed in writing, at any time.

_____ Date: _____

Parent (Signature, If Available)

CLINIC USE ONLY: If Guardian is not present, two staff members shall obtain verbal consent.

Verbal consent phone number: _____ Date:_____

Witness: _____ Witness: _____