KNOX CLINIC
Your Mid Coast Health Net

Consent to Treat Minors

I, _____, am the parent / guardian of _____ - DOB_____. I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to medical care, treatment, and diagnostic tests that the Knox Clinic or its designated associates believe are necessary for this child. I understand that by signing this form, I am giving permission to the medical providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent. I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about this consent.

Delegation of Consent

I hereby authorize (when I am unavailable to give consent) the following individual(s) to consent to any and all medical care and attention for this child which is deemed medically necessary and appropriate by a medical providers of the Knox clinic. This consent includes, but is not limited to elective and emergent care. This delegation shall be valid until I withdraw delegation of consent.

Those to Whom Consent is Delegated:

Name: _____

Relation to patient:_____

Name: _____

Relation to patient:_____

Name: _____

Relation to patient:_____

Signature of Parent / Guardian:_____ Date:_____

Relation to Patient: _____Email_____

Witness:_____ Date:_____