Name: _____ DOB: _____

CONSENT FOR TREATMENT OF A MINOR

Minor Child/Family Representative Consent to Treat without a parent/Guardian Present

I (Parent/Guardian Full Name) _____ give permission for my minor child (Child's Full Name) _____ to receive medical treatment from a provider at Family Medicine of Michigan without a parent or guardian present. Treatment may include immunizations, surgical procedures and any examination/procedure deemed medically neccessary by the treating provider. This consent does not expire unless revoked in writing.

_____ _____

Parent/Guardian Signature Date

Financial Responsibility of Minor

Person financially responsible for said minor information

Name: _____

Last *First* *Middle*

Date of Birth: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

If any dispute arises in regards to Finanical Responsibility, services will not be rendered without court documents or payment in full.

Medical Information Release Form

I hereby give my permission to release any and all medical information regarding myself to family and friends listed below:

(List name and relationship)

_____

_____

_____ _____

Signature of Patient or Legal Guardian Date

The following information will assist us in your care, and in any communications with you, while protecting your confidentiality. Please indicate "Yes" or "No" and complete any necessary information.

I give my permission for Family Medicine of Michigan to:

Leave a message on **HOME Phone**:

Requesting a return call: YES / NO Test Results: YES / NO

Leave a message on **CELL Phone**:

Requesting a return call: YES / NO Test Results: YES / NO

Leave a message on **WORK Phone**:

Requesting a return call: YES / NO Test Results: YES / NO

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient or Legal Guardian Relationship