Kansas Orthopaedic Center

MRN_____

PERMISSION TO ACCOMPANY A MINOR

I, _____, give permission for _____
(Name of Parent/Guardian) (Name of adult to accompany child)
to accompany my child, _____, whose date of birth is _____ and authorize treatment for my child. The accompanying adult's relationship to the child is _____.
(Relationship with Child, such as Grandparent)

This permission and authorization includes bringing the child into the office of Kansas Orthopaedic Center, P.A., providing a history of present illness, disclosing protected health information, signing applicable paperwork, and witnessing any physical exam completed by the provider. This accompanying adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all reasonable charges in connection with care and treatment rendered to my child.

This authorization shall remain effective from _____ to _____.
(effective date) (end date)

(If no dates are specified, this authorization will expire one year after the date signed unless terminated in writing by the undersigned.)

_____ _____
Parent or Legal Guardian's Signature Date

Contact Information for Parent(s)/Guardian(s):

Phone number(s): _____

Address: _____

Comments: _____

7550 W Village Circle Ste 1
Wichita, KS 67205

2450 N Woodlawn Blvd
Wichita, KS 67220

101 E Fulton St
Garden City, KS 67846

PHONE 316-838-2020

FAX 316-838-7574

www.koc-pa.com

(Scan: Consent to Treat Minor)