MOLOKAI
COMMUNITY HEALTH CENTER

CONSENT TO TREAT A MINOR

DATE: _____

NAME: _____ **BIRTH DATE:** _____

PARENT/LEGAL GUARDIAN: _____ **RELATION:** _____

ACKNOWLEDGEMENT:

- I hereby appoint the individuals named below to act as my representative in the event I am unable to bring the child listed above to an appointment.
- Furthermore, I authorize Molokai Community Health Center (MCHC) to render any health services/treatment that is deemed necessary to the child listed above.
- I understand that the individuals named below retain the right to refuse any or all of the recommended health services and treatment.
- I understand that the child listed above will not receive any health services/treatment, if anyone other than the individuals named below brings the child listed above to an appointment.
- I understand the individuals named below must be at least 18 years of age or older.
- I will assume full responsibility for payment of services rendered.
- I understand I may revoke this authorization at any time by notifying MCHC in writing.

NAME: _____ **BIRTH DATE:** _____ **RELATION:** _____

NAME: _____ **BIRTH DATE:** _____ **RELATION:** _____

NAME: _____ **BIRTH DATE:** _____ **RELATION:** _____

NAME: _____ **BIRTH DATE:** _____ **RELATION:** _____

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN (Must present proof of guardianship.) **DATE**