



COLUMBINE
FAMILY PRACTICE, P.C.
Committed to your family's health

CONSENT FORM FOR AUTHORIZATION TO TREAT MINORS WITHOUT
PARENT(S) PRESENT

For families who are ongoing patients of Columbine Family Practice, it may be more convenient to have authorization for medical care delivered directly to minors without a parent having to be present prior to or during treatment. Please review the following authorization for treatment and complete the information if you want to authorize treatment in advance.

AUTHORIZATION

I (we) request and authorize the staff and providers at Columbine Family Practice to deliver care to my (our) child listed below. We understand and recognize that this authorization implies that my (our) child is of an age and ability to understand instructions given by the staff and providers. Every effort will be given to relay information in a clear and simple manner to your child.

PLEASE PRINT

Name of Patient: _____ Date of birth: _____

Name of Parent(s)/Guardian: _____

Phone numbers to try should we need to reach you:

First: _____

Second: _____

Third: _____

Date Authorization is Effective: _____

Signature of Parent(s): _____
