

## Advantage Health Physician Network

---

### ***Consent for Treatment of Minor Without Presence of Parent***

---

\_\_\_\_\_  
Patient's Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
**Mother's** Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
**Father's** Full Name

\_\_\_\_\_  
Date of Birth

I hereby give my consent for the \_\_\_\_\_ office of Advantage Health to provide the following services to the above-named minor child without my presence:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that the above mentioned office will not see my child without my presence unless this authorization is properly signed, and is current. **This authorization is in effect for 1 year from the date signed.**

\_\_\_\_\_  
Mother's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Father's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Witness

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Witness for parent's verbal request

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date