

# *Women's Healthcare of Illinois*

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## **Authorization to Treat Minor**

Date: \_\_\_\_\_

Name of child/minor (patient): \_\_\_\_\_

I, \_\_\_\_\_ being the parent or legal guardian of the above listed child/minor, give my consent to the physicians and staff of Women's Healthcare of Illinois to administer such care, procedures, and treatment that is deemed necessary and in the best interest of the patient.

I understand that this authorization is good until the time in which the child/minor mentioned above reaches her 18<sup>th</sup> birthday or is emancipated.

Signature of parent or guardian: \_\_\_\_\_

## **Minor Consent to Release Information**

(to be signed by the minor)

I, \_\_\_\_\_ hereby  give consent /  do not give consent to Women's Healthcare of Illinois to release confidential medical information about me to:

- Mother
- Father
- Legal Guardian

I understand that this authorization of consent to release information may be revoked in writing by me at any time.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_