A Northside Network Provider

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

Practice Name: _____

I am the parent or legal guardian of the minor child/children identified below:

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

In case of my absence or unavailability, I authorize the following individuals to consent to medical treatment of the child/children named above at the Northside Hospital Affiliated Medical Practice (the "Practice"):

Name of authorized representative	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I agree that I will be financially responsible for and guarantee payment of any and all charges incurred in connection with the rendering of care to my child with the consent of one of the above named individuals.

I understand that health care providers at the Practice may disclose to the authorized individual appropriate information about my child's treatment or condition, such as discharge instructions and information about medication prescribed during that visit.

This authorization will remain in effect until I notify the Practice in writing that I wish to revoke or replace the form.

_____ _____
Witness Date/Time Signature of Parent or Legal Representative Date/Time

_____
Relationship to Patient If Not the Parent

_____ _____
Interpreter Signature Date/Time Reason Patient Unable to Sign

Note: If phone/video interpretation used, record interpreter ID#

Interpreter comments (optional): _____

_____

AUTHORIZATION TO TREAT MINOR