Only Choice Urgent Care
K & J Care Unit, LLC

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Non-Parent Medical Treatment Consent for Minor

(minor* all patients under the age of 18 years)

Name of Child _____ Date of Birth _____

I am the parent or guardian of _____ (legal name of patient). I have the legal right to consent for medical treatment for this child (patient).

I authorize the following individual, who is a person over 18 years of age and whose relationship to the child is:

_____ _____
(Name of individual bringing child to office) (Relationship to Child)

to bring the child to Only Choice Urgent Care, and to consent to medical care which is deemed necessary by the physicians and medical providers at Only Choice Urgent Care at the time of the appointment. I understand that this delegation includes receiving health information about the minor necessary to make immediately necessary health care decisions.

This consent is valid until revoked in writing by me, the parent or legal guardian.

_____ _____
Parent/Legal Guardian Print Name Relationship to Child

_____ _____
Parent/Legal Guardian Signature Date

Contact Information:

Primary Number _____ Cell Phone _____

E-Mail _____

Mailing Address _____

A copy of parent/legal guardian's photo ID must be presented with this form.
You may e-mail both to: onlychoicecare@gmail.com or fax: (281) 324-1555.

We will NOT accept verbal consent over the phone