ADDRESSOGRAPH OR LABEL – PATIENT NAME, MEDICAL RECORD NUMBER

Stanford HEALTH CARE

University HealthCare Alliance

CONSENT TO TREATMENT OF MINOR

I (We), the undersigned, parent(s)/legal guardian/person having legal custody of (*name of minor patient*) _____, a minor, do hereby provide consent to the medical diagnosis, care and treatment of the aforementioned minor patient when he/she presents for care at University HealthCare Alliance without the presence of a parent/legal guardian/person having legal custody.

The undersigned understands that this authorization is given in advance of any specific diagnosis, treatment or care, but it shall provide specific consent to any diagnosis, treatment or care of the minor patient, which is deemed advisable by, and is to be rendered under the general or special supervision of the physicians and authorized medical personnel at University HealthCare Alliance. It is understood that this authorization is specifically limited to procedures and treatments for which informed consent is *not* required, such as allergy injections and general pediatric medicine.

This authorization shall remain effective for a period of one (1) year and shall expire on (*month and day*) _____ ____, 20___, unless sooner revoked in writing by the undersigned individual(s), which revocation shall be delivered to University HealthCare Alliance. Upon the expiration of this consent, a new Consent to Treatment of Minor must be executed before any further diagnosis, treatment or care may be provided to the minor patient when he or she presents for care at University HealthCare Alliance without a parent/legal guardian/person having legal custody.

I authorize permission for my child to attend appointments at University HealthCare Alliance while being accompanied by a designated adult:

_____ _____

#1 Designated Adult Last Name #1 Designated Adult First Name

_____ _____

#2 Designated Adult Last Name #2 Designated Adult First Name

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA contracts with a number of physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford Health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.

Should another adult be designated in the future, I will submit an updated version of this form, or contact your office immediately.

_____

Signed

If interpreted: _____ _____ _____

Interpreter's Signature Print Name Language

_____ _____ _____

Date Time Position/Relationship to Patient