MINOR CONSENT FORM

I, _____, voluntarily consent to the rendering of medical care for _____ by Power of Wellness Health Services.
Child/Minor Name

I acknowledge that no guarantees have been made to me to the effect of any and all medical care provided.

I consent to allow Power of Wellness Health Services to access any and all Private Health Information (PHI) for the listed child/minor above, to which I have legal guardianship, for the purpose of their medical care.

I am aware that I may withdraw this consent at any time by written and/or oral notification.

I am aware that this consent will become null and void once the patient reaches the legal age of eighteen (18).

I hereby give my consent to Power of Wellness Health Services, who will be caring for _____ and agree to allow them to arrange for routine medical care and treatment necessary to preserve the health of the child.

Guardian Signature _____ Date _____ Child/Minor's Name _____

□ Parent □ Legal Guardian

Parent/Guardian Name

_____