



Authorization to Treat Unaccompanied Patient

Patient Name: _____ Patient DOB: _____

I authorize Northland Health Centers to administer such treatment as is necessary for the above-named patient. I hereby confirm that I have read and fully understand this authorization for the above-named patient. I also confirm that no guarantee has been made as to the results that may be obtained.

- ☐ Specific Dates (Please Specify): _____
- ☐ Authorization is valid for one year from today's date

Check all services that apply:

- ☐ Sports Physical
- ☐ Dental Services
- ☐ Behavioral Health Services
- ☐ Medical Services
- ☐ Other: _____
- _____

Parent or Guardian

Name: _____ DOB: _____ Phone Number: _____

Emergency Contact

Name: _____ Relationship to Patient: _____ Phone: _____

X _____

Signature of Parent or Guardian Authorizing Treatment

Date

Permission to treat obtained via phone by NHC Staff:

Staff Name (printed)

X _____
Staff Signature

Date

Time

☐ ☐
AM/PM