FARMINGTON FAMILY PRACTICE

CONSENT FOR DIAGNOSIS AND TREATMENT OF A MINOR

AGREEMENT

I hereby give consent to diagnosis and treatment of the minor, _____, by the physicians of Farmington Family Practice and their staff.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as a result of any proposed treatments or examinations by the medical staff of Farmington Family Practice or their personnel of the above referenced minor.

I understand there are alternative methods of treatment, and risk involved, and the possibility that complication may occur with any treatment proposed. I acknowledge that no guarantees have been made to me concerning the results of diagnostic procedures.

I understand the minor's proposed treatment course may require additional consultation and therapy beyond the initial visit. I hereby give my consent for further diagnostic procedures and further treatment as the need arises in conjunction with this injury/illness. I will not require the health care provider or ancillary staff to obtain additional consent on behalf of the minor for any proposed diagnostic procedure or treatment except for invasive procedures which would require my separate consent.

I recognize by signing this document I am indicating to the health care provider and their staff that I may not be readily available to give my permission either in person or via telephone prior to the minor child seeking treatment at this facility. Therefore, I recognize that the physician and/or health care provider may not have had adequate opportunity to explain to me in full any proposed treatment that could be given to the minor at the time of his/her visit. I recognize this consent is an attempt by the health care provider to accommodate my need to have the minor treated without my presence and/or participation in decisions regarding health care of the minor.

Information from medical records of patients and information received by physicians incident to the physician/patient relationship is kept confidential, and, except for use incident to bona fide medical research, medical or patient education, use in professional review activities of the cost, frequency, and quality of service provided to patients, or necessary in conjunction with the administration of this Agreement, is not disclosed without the consent of the patient's parent or legal guardian.

I hereby give my consent for all non-invasive diagnostic procedures and/or treatment which may occur while the minor is seeking care at this facility.

This Agreement is valid only if the minor is accompanied by one of the following persons: (Strike out if not applicable)

_____ _____

_____ _____

This Agreement shall not expire unless an expiration date is shown here: _____

_____ _____

Signature of Parent Date

_____

Parent's Name Printed