WHITE HOUSE CLINICS

AUTHORIZATION FOR TREATMENT OF A MINOR/ADULT WITH GUARDIAN

My signature below attests that I am the ___ **Biological/Adoptive Parent** for the following patient:

___ **Legal Guardian; or**

___ **Foster Parent**

_____ __ __ / __ __ / __ __ __ __

(Name of Patient) **(Patient DOB)**

This authorization includes all necessary treatment and administration of vaccinations as determined by the treating provider **(foster parents may only give consent for routine health care as defined in form DPP-106A from the Cabinet for Health and Family Services)**. By signing this form, I understand that as of the age of sixteen years, there are certain areas of care my child may seek treatment for without my permission.

FOR BIOLOGICAL/ADOPTIVE PARENTS ONLY –You may list in the space provided below individuals who are given permission to consent for treatment for the above-listed patient and have the same access to the patient's medical records, including the right to disclose the contents to others:

Authorized Individuals:	Relationship to Patient:
_____	_____
_____	_____

FOR MINOR PATIENTS 16 YRS. OF AGE OR OLDER-I authorize the above-referenced minor patient to seek care and treatment without a parent/guardian present.

_____	_____
Signature of Parent/Guardian	Relationship to Patient

I further consent for copies of this minor's immunization records to be released as needed to the following schools/daycares: _____

In order to protect the welfare of the patient, if any court orders/decrees/letters/contracts authorizing medical treatment exist regarding custodial/parental/guardian rights, etc., please be aware that we need to have a copy of these documents in the patient's file.

I understand that I may be subject to legal ramifications if I purposely provide false or inaccurate information to White House Clinics. This release expires one (1) year from the date of signature; unless I choose to revoke this agreement **(termination of the authorization must be received in writing)**.

_____	_____
Signature of Parent/Guardian	Relationship to Patient
_____	_____
Signature of Witness	Date