AUTHORIZATION FOR A MINOR TO BE ACCOMPANIED BY SOMEONE OTHER THAN A PARENT

I, the undersigned, parent or guardian of:

____

Minor's Name Minor's date of birth

do hereby authorize:

Name: ________________________________ Phone: ________________________

Address: ________________________________ Date of Birth: ____________________

to act as agent for the undersigned to give consent to Salud Family Health Centers, its associated clinics or contracted entities, providers and staff ("Salud") to provide medical, dental and behavioral health care services to the Minor during the following year.

It is understood that this is a limited authorization given in advance of any specific diagnosis, treatment or care being required, but it is given to provide said agent with authority and power to give specific consent to any and all such medical, dental, and behavioral health care or treatment which a Salud provider, in the exercise of his or her best judgment, may deem advisable.

This limited authorization gives Salud authority to release the above-named Minor's medical information to the designated agent as necessary to allow the agent to make an informed decision regarding consent to treatment of the Minor.

This limited authorization shall be effective until __________________ unless revoked earlier by the parent or guardian in writing or until the Minor reaches his/her 18th birthday. In any case, the authority granted herein shall not be valid for more than 12 months from the earliest date of this signed document below. I acknowledge responsibility for all charges in connection with care and treatment during the period mentioned above.

Relevant health history of Minor:

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Parent/Legal Guardian Signature Date

____

Witness (Salud staff member) Date