Salud Family Health

**AUTHORIZATION FOR TREATMENT OF A MINOR WITHOUT A PARENT PRESENT**

1. I, the undersigned, parent or guardian of:

   _____

   Minor's Name Minor's date of birth

   do hereby authorize and give consent to Salud Family Health Centers, its associated clinics, providers and staff ("Salud") to provide medical, dental and behavioral health care services to the Minor during the following year, even in my absence, when advised or recommended by a provider at Salud. I understand that it is within a provider's discretion when additional notification, consent or communication is required with the parent or legal guardian when rendering care to the Minor.

2. I understand that it is Salud policy that Minors must be accompanied by a parent or legal guardian to a visit unless the child is 13 years of age or older and I have signed this consent.

3. I understand it is my responsibility to secure transportation for my child to and from the clinic.

4. I understand that I can change my mind later on and decide I do not want my Minor to get services at Salud. If I change my mind, I agree to inform Salud of this decision by notifying a staff member or provider in a Salud clinic.

5. As of the date below, I understand that this consent form remains valid for one year, until Salud receives a written revocation from me, or until the Minor reaches his/her 18th birthday.

6. I understand that Salud needs to cover its expenses. I agree to allow Salud to bill any applicable health insurer. I will provide insurance information to Salud. If I do not have insurance, I agree to discuss the family's eligibility for available public insurance programs or sliding fee scale options with Salud. I acknowledge responsibility for all charges in connection with care and treatment during the period mentioned above.

**Signature of Parent/Legal Guardian:** _____ **Date:** _____

**Print Name of Parent/Legal Guardian:** _____

**Emergency Phone Number**: _____