CHART # ___________

SAN CARLOS APACHE HEALTH CARE CORPORATION

AUTHORIZATION TO CONSENT FOR TREATMENT OF BEHALF OF A MINOR

I am the parent or legal guardian of ____________________________________ a child less than 18 years of age. The following people, each of whom is at least 18 years old, have my permission to seek medical attention and treatment on behalf of my child:

- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________

I understand that the individuals designated above have been authorized to perform a significant function, and I have not given authorization to any individual without due consideration. Further, I will not hold San Carlos Apache HealthCare Corporation or Clarence Wesley Health Center liable for failing to contact me before providing medical treatment to my minor child based upon authorization of one of the individuals I have herein designated.

If, in the future, I have determined that one or more of these designated individuals shall no longer have the right to authorize medical care for my minor child, I agree to notify San Carlos Apache HealthCare Corporation and/or Clarence Wesley Health Center by appearing in person with picture ID and filling out a new form. If I am unable to appear in person, I may give notice in writing, including my signature and social security number, by mail to the Patient Financial Services of San Carlos Apache HealthCare Corporation.

______________________________________	________________________________
Parent/Legal Guardian Signature	Witness Signature (Must be at least 18y.o.)
______________________________________	________________________________
Parent/Legal Guardian Printed Name	Witness Printed Name
______________________________________	________________________________
Date	Date