☐ 302 N. University, Lubbock, TX 79415
Phone: (806) 749-3803 Fax: (806) 749-3805

☐ 1307 Martin Luther King Blvd, Lubbock, TX 79403
Phone: (906) 749-3800 Fax: (806) 749-3802

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

Name of Minor:____ DOB:_____________

I (we) the undersigned parent(s) /guardians(s) of the minor listed above, do hereby authorize the physicians and other health care providers of Lubbock Children's Health Clinic to treat and examine my child and order the examinations, tests, treatments and other services necessary in the best interest of my child. I understand that this consent to treatment will be valid and remain in effect as long as I attend the Lubbock Children's Health Clinic or until I revoke his consent in writing.

I authorize payment of authorized Medicaid or any other private or public insurance benefits to be paid directly to Lubbock Children's Health Clinic or other third party administrator for any services furnished to my child by any Lubbock Children's Health Clinic health care provider. I understand that I am financially responsible to Lubbock Children's Health Clinic for all charges incurred.

I understand that the Health Insurance Portability and Accountability Act authorizes Lubbock Children's Health Clinic to release confidential patient information and/or demographic information for the purposes of obtaining payment for services or to determine eligibility for benefits payable for services provided. *I have been given a copy of the Notice of Privacy Practices for LCHC on______________ (mm/dd/yyyy)*

Signature of Parent/Guardian:____

Father/Guardian Name:___________________
Date of Birth:__________________
SS#:______________________________
Address:______________________________
City, State, ZIP:__________________________
Telephone Number:______________________

Mother/Guardian Name:______________________
Date of Birth:______________________
SS#:_____________________________
Address:_________________________________
City, State, ZIP:____________________________
Telephone Number:________________________

___Yes I am giving permission for LCHC to contact me at the phone numbers listed above. ______(initial)
___No I do not want LCHC to contact me at the phone numbers listed above. _______(initial)
___Yes I would like to receive emails regarding my child's appointment. My email is:________________

** In the event that I am notable to be reasonably contacted or cannot be present when my child requires medical care, the following individuals may bring my minor child to Lubbock Children's Health Clinic for care. I understand that an adult other than the parent or guardian will be required to sign a separate Authorization for Consent for Treatment.

1)____ Relationship:_________________________
2)____ Relationship:_________________________

I certify this form has been explained, that I have read it or had it read to me, and I understand its contents.
Sign:____ Date Signed:______________
Signature of Parent or Guardian