KAISER PERMANENTE®
Health Information Services
11000 E. 45th Avenue, Denver, CO 80239-3004
Phone: **303-404-4700** (TTY **711**)
Fax: 303-409-4950

Place Patient Sticker with Identifying Information Here

CONSENT TO AND DIRECTION FOR TREATMENT OF MINOR

1.1 **Authorization and Consent**. I (We), being the parent(s) or guardian(s), entitled to the care, custody and control of the above minor, do hereby authorize, request and direct you to render such treatment to said minor, including without limitation diagnostic, medical, minor procedures, x-rays, and venipuncture.

1.2 **Unaccompanied by Parent/Guardian**. This consent to treatment is given in contemplation that the above minor may from time to time appear at Kaiser Permanente medical offices and affiliated hospitals, for examination or treatment or both, unaccompanied by an adult, custodial parent or non-custodial parent, because of my (our) absence or unavailability. I (We) hereby authorize, request and direct you to render treatment to said unaccompanied minor, including without limitation diagnostic, medical, minor surgical care, x-rays, venipuncture, and other care that requires a series of treatments to the extent I (we) have previously consented to the series of immunizations and/or treatments.

1.3 **Parent/Guardian Participation**. I (We) understand that at times the physicians, nurses or administrators may deem it advisable that a parent or guardian or other authorized adult be present with said minor for the purposes of assisting in the diagnosis or treatment. I (We) agree to cooperate by being present with said minor at all times possible or when requested.

1.4 **Substitute Decision Maker**. I (we) hereby grant authority to the following adult(s) to consent to care for my minor child should I not be available to provide consent at Kaiser Permanente as allowed by Colorado Revised Statute (C.R.S.) 15-14-105, subject to the following limitations, unless prohibited by law:

Name: _____ Telephone Number: _____ Relationship to Minor: _____

Street Address: _____ City, State, Zip Code: _____

Name: _____ Telephone Number: _____ Relationship to Minor: _____

Street Address: _____ City, State, Zip Code: _____

☐ All non-emergent, non-major care, including immunizations rendered at Kaiser Permanente (*Note: Only a stepparent, adult relative of first or second degree of kinship, or an adult child care provider who has care and control of the minor may consent for immunization of a minor child, per C.R.S. § 25-4-1704)*

☐ Limited treatment, condition(s), procedure(s), and/or treatment(s) (e.g., well-child check-up, dental cleaning and examination, x-ray, venipuncture, etc.) as listed here:

_____

☐ Please contact me (us) in the event a medical decision needs to be made for additional, unanticipated medical services beyond the reason for the patient's visit.

1.5 **Expiration or Termination**. All aspects of this consent will be in effect until specifically terminated or modified by written notice received by Health Information Services at the above address, or on the date the minor becomes an adult under state law.

_____

Signature of parent or guardian | Signature of parent or guardian

_____

(Relationship to minor) | (Relationship to minor)

_____

Date | Time

Note to parent or guardian: This form should be completed for each minor in the family and filed with Kaiser Permanente Health Information Services.