Unity Care NW
Health Care for Everyone

UNACCOMPANIED MINOR AUTHORIZATION

Authorization for Minor Patient (age 13 or older) to be Seen Unaccompanied

Patient Name (Print) _____ Patient Date of Birth (mm/dd/yyyy) _____

As the legally authorized representative, I give consent for this minor patient to be seen unaccompanied and receive health care services in my absence.

Legally Authorized Representative Name (Print) _____

Legally Authorized Representative Signature _____ Date _____

In order to inform me of the risks and benefits of certain procedures, health care for the minor patient may be limited by provider discretion. I can be contacted at the phone number below.

Home Address, City, State, Zip Code _____

( ) _____
Phone Number

STAFF USE ONLY: Authorization obtained by phone for: _____

_____

Staff Name _____ Date _____

This consent will remain in effect unless I revoke it, give an expiration date, or specify reasons it will expire.
Optional: if you want this consent to expire, give the date or conditions below:

Expiration Date: _____

Condition for Expiration: _____

_____