

Haak'u Health Center

Form 8

80 B Veterans Blvd Pueblo of Acoma, New Mexico, 87034

PO Box 40 San Fidel, NM 87049

Telephone (505) 552-5300 ~ FAX (505) 552-5478

Minor Consent From - HHC Proxy Treatment Form

This form gives authorization for a non-parent/non-guardian to accompany your minor patient to appointments and to authorize care during appointments/walk-in visits.

Minor Patient Information			Medical Record #:
_____	_____	_____	_____
First Name	Middle	Last Name	
_____	_____	_____	_____
Address	City	State	Zip
_____	_____	_____	_____
PO Box	City	State	Zip
_____	_____	_____	_____
Date of Birth	_____	Phone number	_____
In case of an emergency, I can be contacted at:	() _____	Home/Cell	_____
	() _____	Work	_____
Child's allergies, if any	_____	Allergies to any medications	_____
Medicine my child is currently taking.	_____	Major Health Conditions	_____
Is the child up to date with vaccination/immunizations	_____	Allergies to any medications	_____
YES <input type="checkbox"/>	NO <input type="checkbox"/>		

The Right to Revoke This Minor Consent Form: As the parent/legal guardian of the patient listed above, you have the right to revoke this consent form at any time by giving written notice to Haak'u Health Center or by completing a new **Minor Consent Form** authorizing new non-parent/non-guardian to accompany your minor child on their next appointments. Please contact **Haak'u Health Center** at (505) 552-5300 for more information if you desire to cancel or update a new authorization.

Proxy Consent Form for Minors

- I authorize the person(s) named on this form to accompany/make decisions regarding the following health services for my child:
 - Regular health care, including but not limited to medical examinations, routine laboratory studies, immunizations, and physical therapy evaluation and treatment.
 - Dental care, including but not limited to, dental hygiene visits, necessary emergency dental care.

(Initials)

_____ **Dental Expectations:** Parent or Guardian **MUST** be present for dental examinations and extractions.

- Eye related services including eye examinations and treatments.
 - Emergency health care for accidents or illness.
 - Behavioral Health/counseling related services.
- The person(s) named on this form has/have agreed to accompany and make decisions regarding the health services listed above.
 - I understand my authorization will remain in effect for the length of the time specified below:

Expiration date (not to exceed one year from the signature date; **form must be updated YEARLY**):

From:

_____ Beginning Date

End:

_____ End Date

NOTE:

- A parent or legal guardian must attend a minor's first visit at Haak'u Health Center.
- A parent or legal guardian must provide this form directly to patient registration or Medical Records staff **in person before** the minor's appointment date. If you are unable to present this form in person, you must fax the form along with a copy of your government ID or Driver's license to the Medical Records fax number (505) 552-1178.
- The form is only valid for the time frame listed on this form. Incomplete form will not be accepted.
- In certain circumstances, in accordance with State and Federal laws, parent or legal guardian permission may not be needed for adolescents being treated for concerns deemed as "heightened sensitivity", including but not limited to STD testing, family planning, mental health, etc.

Authorized non-parent/non-guardian representative information:

1.

_____	_____	_____
First Name	Middle	Last Name
() _____	() _____	
Home Phone Number	Alternative Phone	
_____	_____	
Relationship to Minor	Date of Birth	

2.

_____	_____	_____
First Name	Middle	Last Name
() _____	() _____	
Home Phone Number	Alternative Phone	
_____	_____	
Relationship to Minor	Date of Birth	

I, _____, having had full opportunity to read and consider the content of this
 (parent/guardian name printed)
 authorization form, confirm my agreement for the above-named person(s) to accompany my minor child as named on this form.

_____	_____
Parent/Legal Guardian Signature	Relationship to Minor

Date:	



OFFICE USE ONLY

Phone Verbal Consent (One Day Verbal Consent ONLY)		
HHC Patient Registration Signature and Name:	Date	Time:
HHC Clinical Witness Signature and Name:	Date:	Time:

Consent given by:

Mom: _____ DOB: _____

Dad: _____ DOB: _____

Legal Guardian: _____ DOB: _____

Phone #: _____