SUMMIT MEDICAL GROUP
OREGON
bmc Total Care
Bend Memorial Clinic

Consent for Treatment of a Minor Unaccompanied by a Parent

1. I, the undersigned parent/guardian of the named minor, hereby authorize Summit Medical Group – Oregon (SMG-OR), its physicians and other healthcare professionals (e.g., nurses) to provide routine treatment (well child visits, physical examinations, immunizations and treatments for ordinary illnesses) in my absence.

Minor's Name: _____ Date of Birth: _____

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2. Any **Authorized Representative** listed below has permission to seek medical care for minor in the event a parent/legal guardian cannot be present. This person also has permission to participate in discussions with the provider and staff involving the minor's confidential healthcare information at such time.

Name of Authorized Representative: _____ Relationship to Minor: _____

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3. I understand that medical treatment relating to certain conditions, including emergency care, as described by Oregon law, does not require parental consent.
4. I understand that I may reach out to my minor child's physician with questions regarding the foregoing.
5. I understand that this consent remains effective until revoked in writing by me. I understand that this consent may be revoked by me at any time except to the extent that the Summit Medical Group has already acted in reliance on this authorization.
6. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

□ **Verbal permission given to SMG-OR BMC staff by parent/legal guardian**

Witness #1 Signature:_____ Date:_____

Witness #2 Signature:_____ Date:_____

Comments:

NOTE: *If any special parental or custodial relationship is in place, please explain…*

Parent/Legal Guardian
Printed Name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Legal Guardian
Printed Name: _____ Phone: _____

Signature: _____ Date: _____