The Children's Clinic
WELCOMING FAMILIES SINCE 1911

PERMISSION FOR TREATMENT & DISCLOSURE FOR MINORS

I/we hereby authorize _____, _____
Full Name (please print) **Individuals must be 18 yrs. or older** Relationship to patient

to give consent for the medical and/or surgical treatment and disclosures initialed below that may be required for our minor child/children:

_____ The Children's Clinic may disclose my minor child's/children's medical information to the individual listed when I am not physically present, including disclosures by telephone, fax, secure e-mail or regular mail.

_____ Refill/pick-up medication prescriptions

_____ Call for medical advice

_____ Behavioral health evaluation/treatment

_____ Schedule/cancel appointments

_____ Pick-up completed forms

_____ Other: _____

This Permission for Treatment is effective beginning _____ until _____.

Patient name: _____ Birth date: _____

Physician/Provider: _____

Name of parent/guardian: _____

Home address of parent/guardian: _____

Telephone number of parent/guardian – Home: _____ Cell: _____

Health insurance co.: _____ Member # _____ Group # _____

Nearest relative: _____Telephone: _____

_____ _____
Parent / Legal Guardian Signature Date

_____ _____
Witness Signature Witness Printed Name

The Children's Clinic Portland
Peterkort Centre I
9555 SW Barnes Road
Suite 301
Portland OR 97225
Ph: 503.297.3371
Fax: 503.297.7975

The Children's Clinic Tualatin
Meridian Park Medical Plaza 2
19260 SW 65th Avenue
Suite 340
Tualatin OR 97062
Ph: 503.691.9777
Fax: 503.692.6736

The Children's Clinic Newberg
Deborah Building
700 Deborah Road
Suite 150
Newberg OR 97132
Ph: 503.538.6791
Fax: 503.544.0549

www.childrens-clinic.com