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**UNACCOMPANIED MINOR**

**Melody Cassels, M.D.  
Wesley Glazener, M.D.  
Kendall Burns, D.O.**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 (FIRST) (LAST) (MONTH-DAY-YEAR)

Permission to Treat Unaccompanied Minor 16 and 17 years of age

By law, any child under the age of 18 years old cannot be seen by a doctor without written consent from parent or legal guardian. If the patient is 16 or 17 years old, the child can be seen by themselves with parent or legal guardian’s written consent. By signing below, I request and authorize Austex Pediatrics and staff to deliver routine medical care as deemed necessary or advisable in the diagnosis and treatment of my minor child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work. I have read, understand, and give my consent as stipulated above. I understand I must be available by phone at the time of the visit for verification purposes. I am also aware that I am responsible for payment of the patient portion at the time of service. This consent is effective indefinitely from the date of signature unless revoked by written notice.

Signature of Parent/Legal Guardian

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 (PARENT/LEGAL GUARDIAN) (MONTH-DAY-YEAR)

Printed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_