SIU MEDICINE

Permission to Treat Form

I, _____ give my permission for the
(print name of parent, guardian, or custodian)

following person(s):

_____

Name ***Relationship to Child/Patient (caregiver, grandparent, friend, etc.)***

_____

Name ***Relationship to Child/Patient (caregiver, grandparent, friend, etc.)***

_____

Name ***Relationship to Child/Patient (caregiver, grandparent, friend, etc.)***

to seek medical treatment for the child/children/patient named below:

_____ _____

Child/Patient Name ***Date of Birth***

I understand that this consent is ***valid for one year from the date below,*** and may be revoked at any time by giving written notice.

_____ _____ _____

Signature ***Date*** ***Expiration Date***

_____ _____ _____

Witness ***Date*** ***Expiration Date***

Created: 02/23/2017
Approved by Quality Risk & Safety: 03/15/2017
Approved by Operational & Clinical Performance: 04/12/2017
Approved by Quality & Safety: 04/18/2017