WENTWORTH HEALTH PARTNERS

AUTHORIZATION FOR MINOR
TO ATTEND PROVIDER VISITS WITHOUT A PARENT

Patient/Child's Name _____ Date of Birth _____

1. I, _____authorize _____
(Printed Parent's Name) (Printed Patient/Child's Name)

to attend his/her provider visits without a parent being in attendance.

2. I understand that this form is **NOT** a health care power of attorney, and that I am not granting any other individual the right to independently make health care decisions regarding my child. Instead, the purpose of this form is simply to authorize my child's provider to conduct:

- a routine visit where an ongoing course of treatment has already been established for my child and consented to by a parent; and/or
- a routine physical examination of my child.

3. Regardless of whether a parent is present when my child is treated, health information related to that visit will be shared with me by the provider in accordance with New Hampshire law.

4. I further understand that:

- a new course of treatment for my child will not be started without parental consent;
- no invasive procedures will be performed without parental consent; and
- my child will not receive any vaccinations without parental consent.

5. In addition, I do not want the following medical services provided to my child unless a parent is present (leave blank or write "N/A" if there are no additional limitations):

_____

6. I can be reached at the following number should the provider need to contact me: _____

7. I understand that this form will expire one year from the date of my signature.

_____ _____
Parent's Signature Date