



810 East 23rd Street, P.O. Box 5116 · Sioux Falls, SD 57117-5116
(605) 331-5890 · (888) 331-5890

CONSENT FOR TREATMENT OF MINOR

Patient Name: _____ Date _____

Chart #: _____

I, _____, hereby authorize _____
(Parent/Guardian Name) (Provider(s))

to provide routine medical treatment and/or psychological services for above patient

who resides at home or
 other (please specify _____).

Routine care does not include invasive procedures or other treatments which are unusual or carry a significant risk to the patient.

This consent form can only be revoked by written notification by the parent/guardian.

(Parent/Guardian Signature)

(Date)