



810 E. 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)

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.

Minors requiring an injection for MRI must have a parent/guardian present for the MRI scan.

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

Patient Signature: _____ Date: _____

<p>For Staff Use Only: Permission via phone call</p> <p>Verbal permission given to: _____</p>
