NCH Healthcare Group

PARENTAL CONSENT FOR MEDICAL SERVICES TO MINORS

By signing this consent, I authorize NCH Healthcare Group (NCHHG) to provide medical services without my presence to the minor child/children listed below:

Name of Minor	Date of Birth
Name of Minor	Date of Birth
Name of Minor	Date of Birth
Name of Minor	Date of Birth

If I have any exceptions to the medical services that NCHHG can give, I am stating it here:

I am listing the names of the people that I have given permission to bring my child/children to the medical office in my absence:

Name	Relationship
Name	Relationship
Name	Relationship

This consent pertains only to the minors listed above. Each person who will bring the child/children to the medical office is required to bring picture ID for identification verification.

I understand that I am accepting financial responsibility for all medical services rendered for the patient and that payment is due at the time of service.

I have the right to revoke this consent in writing except to the extent that NCHHG has acted in reliance upon this consent. My written revocation must also be submitted in writing using the Revocation From.

Signature of Parent/Legal Guardian	Relationship to patient
Print Name	Today's Date