



CONSENT FOR TREATMENT OF A MINOR

Date: _____ Time: _____

As ☐ parent ☐ guardian of my ☐ son ☐ daughter ☐ _____ (specify),
named _____, date of birth _____

I hereby authorize the physicians and/or staff of Hartford HealthCare Medical Group to:

☐ Provide medical care to my son/daughter as they deem necessary.

Patient medications: _____

Patient allergies: _____

Insurance name _____

Insurance number _____

☐ Collect a urine specimen for employment purposes

Employers name, address and phone number: (if applicable)

Name of parent/guardian: _____

Signature of parent/guardian: _____

Witness: _____

Date: _____

If verbal consent, HHC MG employee taking consent:

Print name

Signature: _____

Date: _____