COASTAL RADIOLOGY ASSOCIATES, PLLC

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A division of Coastal Radiology Associates

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Consent for Treatment of Minor Child

I, _____, give your physicians and his/her staff permission to perform necessary medical and imaging services on my minor child, _____, DOB: _____.

In my absence, the following people can bring my child to your facility for healthcare services:

PRINT PERSON NAME:	**RELATIONSHIP:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*I understand I must provide your office with a written notice if I want to revoke this consent at any time or make changes. I further understand that others bringing my minor child into your facility for healthcare services may be further exposed to my child's health information. Parent Initials: _____

_____ _____
Parent or Guardian Signature Date

_____ _____
Witness Signature Date