



PARENTAL CONSENT FOR MEDICAL SERVICES TO MINORS

By signing this consent, I authorize Anchor Health Centers (AHC) to provide medical services without my presence to the minor child listed below:

Name of Minor

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

This consent pertains only to the minor listed above.

I understand that I am accepting financial responsibility for all medical services rendered to this minor.

I have the right to revoke this consent in writing except to the extent that AHC has acted in reliance upon this consent. My written revocation must also be submitted in writing using the reverse of this form.

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Patient's Name Date

Print Name of Legal Guardian

ANCHOR HEALTH CENTERS

PARENTAL REVOCATION FOR MEDICAL SERVICES TO MINORS

By signing this revocation, I am reversing the consent that I previously gave Anchor Health Centers (AHC) to provide medical services to the minor listed on the front of this form.

I understand that medical services provided by AHC and the charges associated with those services were made with my consent.

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Patient's Name Date

Print Name of Legal Guardian