RIVER HILLS
COMMUNITY HEALTH CENTER
Diversified Services · Exceptional Healthcare

Consent for Treatment

I hereby give my permission to the providers and personnel of River Hills Community Health Center to assess and treat the health needs of the patient listed below. This permission includes authorization for completion of outpatient diagnostic procedures and immunizations as ordered by River Hills Community Health Center providers.

For Treatment of Minors

(Please complete this section if consenting for a minor or a patient with impaired mental capacity)

Parent/Legal Guardian: Be advised that a minor patient's partner is not considered to be a caregiver and may not consent for medical/dental treatment.

I understand that I should make every effort to accompany my child to appointments. If I am unable to come to an appointment, I give permission to River Hills Community Health Center providers as follows: (choose one)

☐ I will only allow the following named adults to accompany my child:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I will allow the above named adults accompanying my child to consent for:
(Cross off any that **do not** apply)

*Exams
*Lab work
*Other procedures
*Immunizations
*Oral Health Screening/Fluoride Treatment/Sealants

☐ I do not wish to allow another caretaker who brings my child to River Hills Community Health Center to sign for treatment.

I understand that my child may not be seen if he/she arrives at the clinic with a caregiver who does not fit the above chosen guidelines.

I understand that a written permission note signed by me will always be acceptable as consent for any services included in the note.

_____ _____
Patient's Name (Patient/Parent/Guardian/Legal Custodian)

_____ _____
Date Witness