Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

NAME:

ID#

DOB:

PARENTAL CONSENT FOR HEALTH CARE SERVICES AND TREATMENT of MINOR CHILD

(Pursuant to §1014.06, Fla. Stat. (2021))

DATE _____

I, _____, as the ☐ Parent ☐ Guardian, hereby request and authorize
(print name)

_____ ("Provider") and Provider's office staff to provide health
(name and title)

care services and treatment of my minor child_____.
(print name) ("minor child")

I understand that this consent will authorize Provider to provide, solicit and arrange to provide health care services and to prescribe medicinal drugs for my minor child. Health care services may include but are not limited to evaluation, treatment, procedures, and referrals to other specialists.

This consent and authorization is for any time when my minor child is in the care of Provider and is effective as of the Date above until revoked by me in writing.

I have had an opportunity to ask questions and I am satisfied with the answers I received.

_____ _____
(Signature) (Relationship to minor)

_____
Signature of Practitioner (MD, PA, NP, OD)