



AFFIX LABEL HERE

*Neighborhood Doctors Who Care*

**General Consent for Minor's  
Unable to be Accompanied by a Parent of Legal Guardian**

*Completion of this form is required if a parent / legal guardian of a minor desires to give a consent to routine treatments and procedures for the minor in the absence of a parent or legal guardian.*

I, the undersigned parent / legal guardian of \_\_\_\_\_ (name of the minor) (the "Minor) may not be able to accompany the Minor when he or she requires routine medical care. I therefore hereby authorize the staff at Manhattan's Physician Group (MPG) to perform routine treatments and procedures on the Minor, as determined by MPG to be medically indicated.

I understand that this signed consent form only authorizes the performance of routine diagnostic and therapeutic procedures and medical treatments (including immunizations), and that MPG may require, in it's discretion, my presence or a separate consent form for anything that it does not consider to be routine. I also recognize that MPG will take all actions medically necessary in the case of an emergency. This consent is valid for all office visits when the Minor is unaccompanied by me.

I further acknowledge the necessity of requiring an adult to accompany the Minor in my absence. Notwithstanding this necessity, I request that routine treatments and procedures not be withheld if an adult is not available to accompany the Minor.

Authorization to Release Protected Health Information: I authorize MPG to disclose the Minor's protected health information both to the Minor, as well as to an adult who accompanies the Minor. I may revoke my authorization to release protected health information at any time, in writing addressed to MPG, attention Chief Medical Officer, except to the extent that MPG has already taken action based upon such authorization.

In case of an emergency during my absence, please contact:

Name: \_\_\_\_\_

Relationship to the Minor: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

I have read and understand the contents of this consent form that I voluntarily sign. In signing, I do hereby release and hold harmless; MPG, it's employees, staff, agents, and representatives from any and all responsibility or liability resulting from treatment of the Minor in my absence.

Print Name of Parent / Legal Guardian: \_\_\_\_\_

Signature of Parent / Legal Guardian: \_\_\_\_\_

Relationship to Minor: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Documentation of Parent or Legal Guardian's authority has been provided: Yes \_\_\_\_ No \_\_\_\_

Home Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

**WITNESS:** I, \_\_\_\_\_ am an adult employee of Manhattan's Physician Group who is not the patient's Primary Care Provider, and I am attesting to the fact that the above person states that (s)he is authorized to and has signed this form.

\_\_\_\_\_  
Signature of Witness

If the person authorized to give consent and sign this form does not speak English, a translator must sign and date the form.

**TRANSLATOR:** I, \_\_\_\_\_, attest to the fact that, to the best of my knowledge, the person above states that (s)he is authorized to given consent and understand what has been discussed and is voluntarily signing the form.

\_\_\_\_\_  
Signature of Translator and the Language Translated

If this form is not completed at Manhattan's Physician Group, in front of a staff member it must be completed in the presence of a Notary Public.

State of New York, County of: \_\_\_\_\_

Sworn before me this: \_\_\_\_\_ day of \_\_\_\_\_ Year \_\_\_\_\_

Name of Notary Public: \_\_\_\_\_

Signature of Notary Public: \_\_\_\_\_