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completed by \_\_\_\_\_ / \_\_\_\_\_



**CARTERET CLINIC FOR ADOLESCENTS AND CHILDREN**

**Authorization to Consent to Health Care for a Minor  
And for Exchange of Confidential Information**

I, \_\_\_\_\_ of \_\_\_\_\_ County, in \_\_\_\_\_ (state) am the custodial parent having legal custody of \_\_\_\_\_ a minor child born on \_\_\_\_\_ (date).

I authorize \_\_\_\_\_, an adult of \_\_\_\_\_ county in \_\_\_\_\_ (state) to do any acts that may be necessary or proper to provide for the health care of the minor child. This includes, but is not limited to the power (i) to provide for such health care at Carteret Clinic for Adolescents and Children, or the employing of any physician, nurse or other staff whose services may be needed for such health care and (ii) to consent to and authorize any health care, including any labwork, immunizations and the administration of anesthetics, and other procedures by physicians, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

By signing here, I indicate that I understand the importance of assigning health care decisions and understand the full scope and importance of this grant of powers to the adult named herein.

I also hereby give authorization for the exchange of confidential information between the above named adult and **Carteret Clinic for Adolescents and Children**. The purpose for which information is to be exchanged may include medical and/or educational planning, placement, progress, or referral information. This consent will be in effect for one year from the date of signature or until revoked in writing.

Custodial Parent's signature \_\_\_\_\_ DATE: \_\_\_\_\_

Please PRINT name: \_\_\_\_\_

Witness: \_\_\_\_\_ DATE: \_\_\_\_\_

**REVOCATION OF AUTHORIZATION**

REVOKED ON (DATE): \_\_\_\_\_ BY (PRINT NAME) \_\_\_\_\_

Signature: \_\_\_\_\_