Tandem Primary Care

Individually guided. Holistic minded. Community united.

MINOR CONSENT FORM

Patient Name:_____

DOB: _____

I hereby authorize employees and medical providers of Tandem Primary Care to render medical evaluation and treatment to the patient listed above. The duration of this consent is annually. We will renew yearly unless a written request to revoke is provided. I understand that by not signing this consent, the patient(s) listed below will not be provided medical care except in the case of an emergency.

Name of Legal Guardian:_____

Relationship to Patient:_____

Signature of Legal Guardian:_____

Date: _____

Tandem Primary Care

Individually guided. Holistic minded. Community united.

TRANSFER OF CONSENT TO ANOTHER PARTY

Patient Name:_____

Patient DOB: _____

I hereby authorize the following person(s) to consent to medical treatment for the above named child/children in my absence. Please include relationship and age or date of birth.

Name:_____

Relationship to Patient:_____

DOB: _____

Signature of Legal Guardian: _____

Date:_____

Tandem Primary Care

Individually guided. Holistic minded. Community united.

CONSENT FOR TEENAGE CHILD TO SEEK TREATMENT

Patient Name:_____

DOB: _____

I hereby authorize my teenage child/children to seek medical treatment in my absence.

Name of Legal Guardian:_____

Signature of Legal Guardian: _____

Date:_____