Longmont - Boulder
Sports Chiropractic

# Consent to Treat Minor Patient

## Consent To Treating Your Minor Patient

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's name: _____DOB:_____

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:
Name: _____Relationship to Patient :_____
Name:_____Relationship to Patient :_____

**LIMITATIONS**: Identify any specific limitations on the kinds of chiropractic services for which this authorization is given. (If none, state "none")

_____

□Check here if you wish to give consent for the minor to receive chiropractic care without an accompanying adult. This consent may only apply to minors age 16 and older. This consent shall be in effect for: □Date_____ (only) □Indefinitely, until revoked by written communication

**AUTHORIZATION**: I (parent/legal guardian name) _____ request and authorize LoBo Sports Chiropractic and its personnel to deliver routine chiropractic care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment at the time of service. I have the legal right to preauthorize LoBo Sports Chiropractic and its personnel to deliver routine chiropractic, and therapeutic treatment to my child. Routine chiropractic care may include, but is not limited to: chiropractic evaluation, chiropractic adjustment, soft tissue work, and therapeutic exercises. By signing below I state that I have weighed the risks involved & give my consent to treat and to accept chiropractic care on this basis for my child. I have read, understood, and given my consent as stipulated above.

_____

Parent or Legal Guardian (please print) Relationship

_____

Parent or Legal Guardian Signature Date

HIPAA Required Statement: I understand that non-research treatment may not be conditioned upon signing this release. I understand that the information provided under this release may be subject to redisclosure by the receipt under circumstances no longer protected by HIPAA privacy rules. I understand that I may revoke this release at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must provide written notice to the doctor or health care provider named in the release and written notice to the organization or entity to whom I have authorized the release of information.

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# PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

**Patient must provide complete/accurate information, LoBo Sports Chiropractic will only process valid/complete authorization form.**

## PATIENT INFORMATION:

**Last Name** _____ **First Name** _____**MI** ___ **DOB** _____

**Address** _____ **City** _____**State** _____ **Zip** _____

**Phone** _____ **Email** _____

***I authorize and request release of:*** (*Check the following*)

□All Healthcare Records □Films/ X-rays

□Other_____

**First and Last Name**_____**Signature** _____

***I authorize LoBo Sports Chiropractic to release my health care information to:***

**Name (Individual/Clinic/Organization)** _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Phone** _____ **Email** _____ **Fax** _____

**Purpose or need for which information is to be used: (***Check the following*)

□Damage/Claim Evaluation and Presentation □ At request of the Individual □ Other _____

**Authorization:** I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient, but in any event on _____ (*Date supplied by patient*) or _____ days hereafter.

Printed name of patient: _____

Patient Signature:_____ Date:_____

Signature of Parent/Guardian (if minor):_____Date:_____

*To be completed by front staff:* Witness Signature:_____Date:_____

HIPAA Required Statement: I understand that non-research treatment may not be conditioned upon signing this release. I understand that the information provided under this release may be subject to redisclosure by the receipt under circumstances no longer protected by HIPAA privacy rules. I understand that I may revoke this release at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must provide written notice to the doctor or health care provider named in the release and written notice to the organization or entity to whom I have authorized the release of information.