Reliance Medical Associates, PLLC

107 Glen Oak Blvd, Suite 200
Hendersonville. TN 37075
Tele: (615) 822-1993
Fax: (615) 822-2055

Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

Patient Name _____DOB _____

I give permission to the physicians, providers and nurses of Reliance Medical Associates to treat my child in my absence. I authorize any medical treatment which may be necessary in an emergency, and in my absence, for the wellbeing of the above-mentioned minor. It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician / provider to diagnose and treat the child even when the parent or guardian is not present.

Name of Parent or Legal Guardian*: _____

Relationship to Child: _____

(Print Name) / Contact Number(s):

_____

Address: _____

City, State, Zip: _____

Signature: _____ Date: _____

*If Power of Attorney is required to show legal guardianship, you will be required to show Power of Attorney paperwork. This Consent is effective until withdrawn in writing by the child's parent or guardian or until child turns 18 years of age.