HEALTH CARE AUTHORIZATION & CONSENT FOR TREATMENT OF MINORS

I, ____ *(insert name of natural or adoptive parent, or legal guardian of minor patient)*, as the natural or adoptive parent or legal guardian of minor patient named below, have legal authority to and give authorization and consent to Baptist Health System, Inc., its subsidiaries, and their respective physicians, nurses and other health care practitioners and staff ("Baptist Health Providers"), to provide, solicit, or arrange to provide, health care services and treatment, which includes mental health services and treatment, to ____ *(insert name of minor patient)*, whose date of birth is: ____________ . I understand that health care services and treatment may include the use of x-rays, scans, laboratory tests, prescription medications, administration of medications and vaccines, records of the minor patient's blood or deoxyribonucleiuc acid (DNA), and other diagnostic procedures and tests typically provided in a health care setting.

Further, when the named minor patient's blood or DNA is clinically necessary to treat the named minor patient, I give authorization and consent to Baptist Health Providers to create, store, or share records of the named minor patient's blood or DNA.

I further give authorization and consent to Baptist Health Providers to provide, solicit, or arrange to provide health care services and treatment to the named minor patient when they are accompanied by the minor's stepparent, grandparent, adult brother or sister, aunt or uncle or the following individual(s) in my absence:

____ ______________________________

Name of Authorized Individual | Relationship to Minor Patient

____ ______________________________

Name of Authorized Individual | Relationship to Minor Patient

This authorization and consent is valid for: (a) one year from the date of the parent's signature for office visits, or (b) one encounter for hospital inpatient services or one series of encounters for hospital services stemming from a single regimen. I understand the above statements and that I may revoke this authorization and consent at any time.

____

Print name of patient's natural or adoptive parent, or legal guardian

____

Signature *(natural or adoptive parent or legal guardian)* | Date | Time

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PATIENT LABEL