

**Authorization for Treatment of a Minor**

I am the parent or guardian of , currently a minor whose date of birth is / / .

I authorize Colorado State University CSU Health Network to provide medical and/or mental health care to my son/daughter, including but not limited to, diagnostic examinations (including radiological and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, and necessary medical treatment including minor surgical procedures, and mental health counseling.

I understand that should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand that once my child reaches the age of majority, my consent for treatment is no longer required.

Signature Date

Printed name Relationship

Received verbal/phone authorization (only used if treatment is needed):

 Signature CSU Medical Records personnel

 Date

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Signature Date

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