Consent for Care of Minor by Proxy

Child Guidance Center of Southern CT (CGC) has formed an alliance with Community Health Center, Inc. (CHC).
Your CGC providers will continue to provide your care at the same location(s).
CHC will provide billing and administrative services. Please let the front desk or your provider know of any questions.

Consent for Care of Minor by Proxy

By Law, with some limited exceptions, any child under the age of 18 years old cannot be seen by a licensed provider without consent from a parent or legal guardian. If that minor arrives with someone other than a parent or legal guardian, and no exception applies, we must have written permission from the parent or legal guardian that the accompanying adult, listed below, has been appointed by you to act on your behalf. For those occasions when you may not be with your child, please provide a list of individuals that you give permission to give us consent in order to see your child. This form does not replace School-Based enrollment forms that address consent for treatment.

I give my permission, as parent or legal guardian of _____, for the below listed adults to accompany my child to be seen at Community Health Center, Inc. for routine (Please check all that apply):

☐ Medical ☐ Dental ☐ Behavioral health services

Routine care shall include, but is not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, dental restorative visits, dental preventative visits, behavioral health therapy visits, and lab work.

Accompanying Adult:	Relationship to Patient:	Phone:	Expiration Date:
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**Note Accompanying adult will need to provide identification when arriving with patient

LIMITATIONS:
Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none."

_____

_____

CONTACT INFORMATION:
If the nature of the medical care is not routine (defined above), please try to contact me (us) regarding the health care of my (our) children/dependents at the following telephone number(s). If you are unable for any reason to contact me (us) you may rely on the proxy decision maker for consent:

Parent/Guardian's Name:	Daytime Phone:	Evening Phone:	Cell Phone:
Parent/Guardian's Name:	Daytime Phone:	Evening Phone:	Cell Phone:

AUTHORIZATION:
I (parent/legal guardian) _____ request and authorize that Community Health Center Inc. (CHC) and its personnel to deliver routine care to my child/dependent listed above as may be deemed necessary in the diagnosis and treatment of the minor child. I have the legal right to authorize CHC and its personnel to deliver routine medical treatment and services to my child.

Parent/Legal Guardian (Signature):_____ Relationship:_____ Date:_____

**Under no circumstances will a minor be seen for an initial visit unless accompanied by a parent or guardian, except as allowed by law.