Name: _____ Chart/Billing ID#: _____

DOB: _____ SSN#: _____

Teche Action Board, Inc
ABSENT PARENT CONSENT FOR TREATMENT FORM

I, _____, am the legal guardian for the above named patient and I **authorize the following named individuals to accompany my child in my absence to receive medical and/or behavioral treatment at Teche Action Clinic.** By signing this authorization, I am granting permission for the listed individuals to sign any legal documents such as Consents, Authorizations to Release/Request Information, etc. This authorization will be valid for one (1) year. If I must make any changes in authorized individuals, I must inform Teche Action Clinic in writing immediately.

Authorized individuals are (*Please Print*):

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ _____

Signature of Parent/Guardian/Authorized Representative Date

_____

Witness Signature

Your Primary Care Medical Home

Revised 10-06-2020