Tillamook County Community Health Centers

Our Mission . . . To protect and promote the health of all people in Tillamook County.

MR#_____

CONSENT FOR CHILD TO BE SEEN

Patient Name: _____DOB: _____

Please **initial** next to the appropriate section below:

_____ I, the legal guardian of the child listed above, authorize for my child to be treated at a Tillamook County Community Health Centers (TCCHC) facility even if I am not present, as long as the following person(s) over the age of 18 is/are present:

Name	**Relationship to Patient**

-OR-

_____ I wish for the child listed above to be treated at a TCCHC facility only if a legal guardian is present.

I understand this authorization will expire in one year unless otherwise indicated. I understand I may revoke this authorization, in writing, at any time.

_____

Legal Guardian Signature **Date**

_____

Relationship to Patient