PARENTAL CONSENT

I, _____, hereby consent to authorize the professional staff at Uinta Medical Group to furnish any and all diagnostic services, therapeutic services, assessments and supplies to which I may from time to time require for treatment of my medical condition(s) then existing, and including but not limited to, medical history, physical examination, assessment of health status, emergency procedures, medication history, and immunization history. I acknowledge that I may at any time request my information from the professional staff at Uinta Medical Group as to any diagnostic, assessment or therapeutic services or supplies rendered to me.

I acknowledge that I have read this consent (or have had this consent read to me) and understand its contents.

Student Signature _____

Student Name (Print) _____

Date _____

If the patient is a minor (under the age of 18) or the patient is unable to sign or give consent-

Signature (Legal Guardian) _____

Print Name _____

Date _____

Please Select:

☐ **Parent**

☐ **Legal Guardian**