Ilanka Community Health Center
705 Second Street – PO Box 2290
Cordova, AK 99574
Ph: 907-424-3622 Fax: 907-424-3275

CONSENT TO TREAT

I, ________________________________, give consent to Ilanka Community Health Center to provide treatment and/or necessary procedures to my minor child.

____
Child's Name   Date of Birth

____   __________________
Parent/Guardian Printed Name   Date

____   __________________
Parent/Guardian Signature   Date

This authorization is valid:

☐ For a limited time. From ___________________ to ____________________
(date)   (date)

☐ Ongoing until withdrawn

I authorize the following adults to accompany this minor child noted above to seek and obtain medical care and treatment from Ilanka Community Health Center:

____   _________________________
Name   Relationship to Child

____   _________________________
Name   Relationship to Child

____   _________________________
Name   Relationship to Child

I understand that I am authorizing the above named adults the ability to make medical decisions for my child on my behalf, in my absence. I further understand that I remain the financially responsible party for my child's medical care.

____   __________________
Parent/Guardian Signature   Date