Pueblo Community Health Center

Your Health. Our Mission.

Delegated Consent to Treat Form

I (We) _____ and _____ of
(Name) (2nd Name, if applicable)

_____, _____, hereby state that I/we, the parent(s)
(City) (State)

or legal guardian(s) of _____, a minor, born on _____
(Minor Childs Name) (DOB)

authorize _____, an adult, who resides at
(Name)

_____, _____, _____
(Address) (City) (State)

to consent to any necessary examination, medical diagnosis or treatment to be

rendered to the above named minor under the general or special supervision and on the

advice of any provider licensed to practice at Pueblo Community Health Center.

Dated this _____ day of _____, 20____

_____ _____
(signature of parent/guardian) (signature of PCHC representative)

OR

_____ _____
(signature of parent/guardian) (Notary Public)

my commission expires on_____