CANONCITO BAND OF NAVAJOS
HEALTH CENTER INC.
129 Medicine Horse Drive – To'Hajiilee, NM 87026
Phone (505) 908-2307 / Fax (505) 908-2310

PARENT / LEGAL GUARDIAN AUTHORIZATION FOR MINOR TO RECEIVE CARE AT CBNHC

This form gives your authorization for a non-parent/non-guardian to accompany your minor patient to appointments and to authorize care during appointments/walk-in visits. **Signing this form does not authorize release of medical records**. *Please fill out both sides of form.*

PART A: Minor Patient Information

_____ _____ _____
First Name Middle Last Name

_____ _____ _____
Address City/State Zip

_____ _____
Date of Birth Home Phone #

PART B: Your Rights

YOUR RIGHT TO REVOKE: You may revoke this authorization at any time by giving written notice to CBN Health Center, Inc. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. Please contact CBN Health Center, Inc. for more information if you desire to cancel this authorization.

PART C: Authorization to Accompany Minor

1. I authorize the person(s) named on the bank of this authorization form to accompany/make decisions regarding the following health services for my child:
   a. Regular health care, including but not limited to medical examinations, routine laboratory studies, immunizations, and physical therapy evaluation and treatment.
   b. Dental care, including but not limited to dental examinations, preventive use of fluorides, necessary emergency dental care, and extractions.
   c. Eye related services including eye examinations and treatments.
   d. Emergency health care for accidents or illness.
2. The person(s) named on the back of this form has/have agreed to accompany and make decisions regarding the health services listed above.
3. I understand my authorization will remain in effect for the length of the time specified below:
   ☐ **Expiration date (not to exceed one year; form must be completed yearly):**
   From_____ / _____ / _____ **To** _____ / _____ / _____
   Beginning Date End Date

Patient Name: _____

Health Record # _____

Authorization for Minor to Receive Care

4. Authorized Patient Representative Information:

A. _____ _____ _____
First Name **Middle** **Last Name**

_____ _____
My Representative's Relationship to Me **Date of Birth**

_____ _____
Home Phone **Alternative Phone**

_____

B. _____ _____ _____
First Name **Middle** **Last Name**

_____ _____
My Representative's Relationship to Me **Date of Birth**

_____ _____
Home Phone **Alternative Phone**

_____

C. _____ _____ _____
First Name **Middle** **Last Name**

_____ _____
My Representative's Relationship to Me **Date of Birth**

_____ _____
Home Phone **Alternative Phone**

_____

I, _____, having had full opportunity to read and consider the contents of this authorization, confirm my agreement for the above named person(s) to accompany my minor child as named on this form.

Parent/Legal Guardian Signature:_____ Date:_____

_____ _____ _____
CBNHC Staff Print Name **CBNHC Staff Signature** **Date**

_____

Patient Name: _____

Health Record # _____