all american orthopedic
& SPORTS MEDICINE INSTITUTE

CONSENT TO TREAT A MINOR

M. Shaun Holt, MD * Jeffrey Jaglowski, MD * Matthew Higgs, MD

Anthony Muffoletto, MD * Lauren Hinojosa, MD

Patient's Name _____ DOB _____

Patient's Address _____ City, State, Zip _____

Patient's Phone _____ Parent's Phone _____

I, _____, parent/ legal guardian of _____, do hereby consent to any medical care of and administration of medications determined by a physician to be necessary for the welfare of my child while said child is under the care of the above named physician and/ or their staff.

I do hereby indemnify and hold harmless the physicians and other healthcare workers who act in reliance with this authorization.

_____ _____

Signature of Parent/ Guardian Date

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I request and authorize the physician and/or physician's representative (physician) _____ to release healthcare information of the patient named above to:

Names of trainers/coaches/other physicians/ other _____

Signature of Patient or Representative _____

Relationship to student _____

Student Signature _____ Date: _____