CLINIC NETWORK
PULLMAN REGIONAL HOSPITAL

Palouse Heart Center
Palouse Pediatrics
Palouse Psychiatry & Behavioral Health
Palouse Pulmonology & Sleep Medicine
Pullman Family Medicine
Palouse Health Center

Advanced Consent for the Treatment of a Minor

Patient (Minor's name): ________________________ Patient's Date of Birth: ___________________

Patient Account #: ____________________________

Date: ___________________________

I, ______________________________, the parent or guardian of, ___________________________
(Printed Name of Parent/Guardian) (Printed Name of Patient)

authorize and give consent to Pullman Regional Hospital Clinic Network to provide routine and emergency medical treatment for my child or dependent when deemed necessary by qualified medical personnel. This authorization is given in advance of any specific treatment being required and I waive my right to prior informed consent to such treatment. This authorization will be in effect until revoked in writing by me.

In addition to this consent form, I have read the "Important Information to Parents of Minors" form and understand that my minor child has the right to consent to certain healthcare without a parent or guardian's consent.

_____________________________________ _____________________________________
Printed name of Parent/Guardian Contact Phone Number for Parent/Guarantor

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Signature of Parent/Guardian