University of Bridgeport/UB Clinics
60 Lafayette Street
Bridgeport, CT 06604
Phone: 203-576-4349 Fax: 203-576-4776

Consent to Treat A Minor

Patient Name: ___________________________________

Date of Birth: ___________________________________

I hereby request and authorize the supervising doctors and student interns to perform diagnostic tests and render any necessary treatments to my minor child listed above. This authorization also extends to office staff members. This includes radiographic examination (x-rays) at the doctor's discretion.

As of this date, I have the legal right to select and authorize healthcare services for the minor child named above.

Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

______________________________	______________________________
Date	Signature
______________________________	______________________________
Witness Signature	Print Name
	______________________________
	Relationship to Patient

4/2021