

Miami Debate Institute
AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I/We, parent(s) or legal guardian of

_____ (Patient's Name)

_____ (Date of Birth)

_____ (Social Security #)

an unemancipated minor who is a participant in the Miami Debate Institute, do hereby consent to an X-ray examination, anesthetic, medical or surgical diagnosis or treatment and medical care which is deemed advisable by and is to be rendered under the general supervision of any physician or surgeon on the medical staff of the Miami University Health Services Center or McCullough-Hyde Hospital, whether such a diagnosis or treatment is rendered at the Health Services Center or at the Hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or medical care being required and is to serve as specific consent to any and all such diagnoses, treatment, or hospital care which may be deemed advisable. I further authorize the program director or residence hall supervisors to administer non-prescription analgesics for minor medical problems such as headaches, etc.

_____ (Parent/Guardian Signature)

_____ (Date)

_____ (Witness Signature)

_____ (Date)

(Consent expires six months from date of signing.)

COMMERCIAL INSURANCE

Patient Address

_____ Street Address

_____ City

_____ State

_____ Zip Code

Patient Phone # _____

Insurance Company _____

Insurance Co. Address _____

Insurance Co. Phone _____

Policyholder's Name _____

Policy # _____

Policyholder's Address _____

Relationship to Patient _____

Contract # _____

Employee Number _____

I hereby authorize the Miami University Health Services Center to release any medical information that might be needed in connection with payment for medical services. I furthermore request that payment under my medical insurance program be made directly to the Miami University Health Services Center on any bills for services rendered at that facility. I understand that I am financially responsible to the Miami University Health Services Center for fees not covered by this authorization.

Patient Signature _____

Date _____

Parent/Guardian _____

Date _____