CSU HEALTH NETWORK
COLORADO STATE UNIVERSITY

Authorization for Treatment of a Minor

I am the parent or guardian of _____, currently a minor whose date of birth is _____/_____/_____.

I authorize Colorado State University CSU Health Network to provide medical and/or mental health care to my son/daughter, including but not limited to, diagnostic examinations (including radiological and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, and necessary medical treatment including minor surgical procedures, and mental health counseling.

I understand that should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand that, once my child reaches the age of majority, my consent for treatment is no longer required.

_____ _____
Signature Date

_____ _____
Printed name Relationship

Received verbal/phone authorization: _____
Signature Medical Records personnel

_____
Date

☐ I am living apart from my parent(s) or legal guardian, and managing my own financial affairs. I consider myself emancipated.

_____ _____
Signature Date