



MINOR CONSENT FORM

I give my consent for _____ to bring

(name of minor) _____

(date of birth) _____ to the FamilyHealth Medical Clinic for medical care and treatment.

This authorization is in effect for one year unless notified in writing that the authorization should be terminated.

Signature of parent or legal guardian: _____

Date: _____

FamilyHealth Medical Clinic - Northfield
2000 North Avenue
Northfield, MN 55057-1697
Phone: (507) 646-1494

FamilyHealth Medical Clinic - Farmington
4645 Knutsen Drive
Farmington, MN 55024-8455
Phone: (651) 460-2300

FamilyHealth Medical Clinic - Lakeville
9974 214th St. W.
Lakeville, MN 55044
Phone: (952) 469-0500

FamilyHealth Medical Clinic of Lonsdale
103 - 15th Avenue S.E.
Lonsdale, MN 55046-5001
Phone: (507) 744-3245

Orthopaedic and Fracture Clinic of Northfield
1381 Jefferson Road
Northfield, MN 55057-3080
Phone: (507) 646-8900

Women's Health Center of Northfield Hospital
2000 North Avenue
Northfield, MN 55057-1697
Phone: (507) 646-1478