Northfield Hospital + Clinics
2000 North Ave, Northfield MN 55057

Authorization For Minor Consent Form

Name of Minor: _____

Date of Birth: _____

❒ Decline

❒ By checking this box, I give minor consent to be seen for medical treatment without parent present.

I give consent for the following individuals to bring in for medical treatment and/or received and discuss medical information with Northfield Hospital & Clinics:

1. _____

2. _____

3. _____

This Authorization for Minor Consent Form will remain in effect for one year from date of signature unless Northfield Hospital & Clinics is notified in writing that this authorization should be terminated.

Signature of Parent or Legal Guardian: _____

Date: _____