

CAROLINA WOMEN'S HEALTH, PA
DR. J. STEWART CARR, MD
3404 WAKE FOREST ROAD, SUITE 200
RALEIGH, NC 27609

CONSENT TO TREATMENT OF A MINOR

MINOR PATIENT NAME: _____

MINOR PATIENT DATE OF BIRTH: _____

MINOR PATIENT PHONE NUMBER: _____

MINOR AGE AT DATE OF CONSENT: _____

As legal guardian, I hereby give my consent to treat _____, a minor patient. I understand that by giving consent, I am allowing Dr. J. Stewart Carr, MD to diagnose and treat this patient without regard to diagnosis or condition. I understand that in emergency situations, a consent would not be needed, and this patient would be treated regardless of parental consent.

LEGAL GUARDIAN NAME: _____

SIGNATURE OF GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____

CONTACT PHONE NUMBER: _____

DATE OF CONSENT GIVEN: _____

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For office use only

Received by: _____ on this day _____

Scanned into patient record on: _____ (date)