Confederated Tribes of Siletz Indians
Siletz Community Health Clinic
Post Office Box 320 • 200 Gwee-Shut RD
Siletz, OR 97380
Telephone: 800-648-0449 • (541)444-1030
Facsimile: (541)444-9695

CONSENT FOR TREATMENT

I, the undersigned, am the parent/legal guardian of child patient or am the patient,

_____,

date of birth _____ , hereby authorize and give my permission to the following person(s) to act in my behalf to consent and seek care deemed necessary where my initials are below:

Name	Relationship
Name	Relationship
Name	Relationship

Dental:_____ Medical:_____ Optometry:_____

I understand this Consent for Treatment is **valid for one year from the date signed** unless I submit revocation in writing to the Siletz Community Health Clinic (SCHC). SCHC may revoke this Consent for Treatment in the event any of the authorized persons, the patient or the parent/legal guardian violates SCHC policy.

Signature	*Date*
Printed Name	Relationship Example Patient, Parent, Legal Guardian, etc.

SCHC HEALTH INFORMATION USE ONLY:

Scanned _____ MRN _____ Consent Expires _____