BIENVILLE
Orthopaedic Specialists

# Minor Child Treatment Release Form

In my absence, I, _____, hereby give the following individual(s) permission to bring my child, _____, to Bienville Orthopaedic Specialists to be treated for any medical condition.

I also authorize the Physicians, Nurse Practitioners, Physician Assistants, and staff to release any information including, but not limited to the diagnosis and the records of any treatment rendered to my child during the period of care to the names listed below.

**Please include any family members, caregivers, coaches, or athletic trainers**

| | |
|---|---|
| _____ Full Name | _____ Relationship |
| _____ Full Name | _____ Relationship |
| _____ Full Name | _____ Relationship |
| _____ Full Name | _____ Relationship |

I understand that as the parent, I may revoke the Minor Child Treatment Release Form at any time by providing written notice to the person or organization making the discosure.

| | |
|---|---|
| _____ Signature (Patient, Parent or Legal Guardian) | _____ Date |
| _____ Witness Signature | _____ Date |

**Expires One Year From Above Date**