C.W. WILLIAMS
Community Health Center, Inc.
Healing Heart, Mind & Soul!

GENERAL CONSENT FOR TREATMENT

I, the undersigned, grant permission for my minor child(ren) to undergo all necessary tests, examinations, treatments, and other procedures required in the course of study, diagnosis, and treatment by medical & dental practitioners and other staff members of The C. W. Williams Community Health Center, Inc. (CWWCHC). I also grant permission for my minor child(ren) to receive a COVID-19 vaccination.

I am aware that the practice of medicine and minor surgery is not an exact science, and I acknowledge that no guarantees have been made to me regarding results of treatments or examinations by The C. W. Williams Community Health Center, Inc.

I also consent to the release of my/my child's/children's medical information to authorized institutions, agencies, and insurers. I further grant permission to release personal and medical data to associated agencies (such as laboratories, etc.), as is required by The C. W. Williams Community Health Center, Inc.

I also hereby authorize payment to The C. W. Williams Community Health Center, Inc. of Medicaid, Medicare, and/or third party insurance benefits on my/my child's/children's behalf for services rendered by CWWCHC.

_____ _____
Name of Minor Patient (Please print above) Date of Birth

_____ _____
Name of Parent or Legal Guardian (Please print) Parent/Guardian's Date of Birth

_____ _____
Signature of Parent or Legal Guardian (Sign above) Today's Date

_____
Address of Patient/Legal Guardian (Please print above)

_____ _____
Email Address Phone

_____
Name of Medical Insurance Carrier, if applicable (Please print above)

_____ _____
Medical Insurance ID Number Medical Insurance Plan Number

_____ _____
Policy Holder's Name Employer

_____
Name of Dental Insurance Carrier, if applicable (Please print above)

_____ _____
Dental Insurance ID Number Dental Insurance Plan Number

_____ _____
Policy Holder's Name Employer