AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT OF A MINOR

UNACCOMPANIED BY PARENT OR LEGAL GUARDIAN

In my absence, I _____, who has legal custody of my child, _____ and whose date of birth is _____ authorize the following individuals:

1. Name:_____ Relationship to the Patient:_____
2. Name:_____ Relationship to the Patient:_____
3. Name:_____ Relationship to the Patient:_____

to provide consent to ABC Pediatrics to render care under the supervision and advice of a licensed medical care professional. I understand that it may be necessary to perform diagnostic testing and/or to administer vaccinations in the course of the visit.

I consent to all medically services rendered during the visit in which I was absent for example, physical examination, hearing and vision testing, immunizations, treatment for illness, referrals to a specialist, etc. The above named person(s) may also receive any tests results and any additional medical information pertinent to the care and treatment of the minor child for the visit in which I was absent. The above named person(s) listed above may not request full medical records or make decisions about chronic conditions without written consent from the parents/legal guardians.

I do not consent to the following services:

_____.

This written consent is valid for the time period of: _____ to _____.

After a period of one year, a new consent form would need to be completed. This consent may be revoked by me at any time in writing.

_____ _____

Parent or Legal Guardian's Name Date

_____ _____

Parent or Legal Guardian's Signature Date

_____

Phone Number Where Parent or Guardian Can Be Reached

October 2020