PEDIATRIC
associates

Date _____

PARENTAL ADVANCE CONSENT TO TREAT MINORS

Authorization for Pediatric Associates:

I hereby authorize and consent to routine and emergency medical treatment for my child by qualified medical personnel at Pediatric Associates. I authorize and consent to emergency medical treatment when deemed necessary or advisable to safeguard my child's immediate health, and I cannot be reached within a reasonable time by reason of absence for the community or otherwise. I waive my right to informed consent to such treatment with the understanding what every attempt to contact me has been made.

_____

Signature Printed name Relationship to patient Date

Other Authorization:

This is to certify that the person(s) **(not parents)** listed below has my permission to authorize necessary medical care for my child, in the event that I am unable to accompany my child to their doctor's appointment. This authorization will be in effect until revoked in writing by me. I accept financial responsibility for necessary treatment and services.

_____

Name Relationship to patient Phone number

_____

Name Relationship to patient Phone number

Does the above named person(s) have permission to speak with Pediatric Associates over the phone regarding your child's health care information? Yes ☐ No ☐

_____

Signature Printed name Relationship to patient Date

_____

Patient Name Date of Birth