PATIENT NAME: __________________________ DOB: ______________

If the patient is 15 years of age or older, the patient must complete and sign this form. We will only discuss medical care with individuals listed on this form.

CONSENT FOR TREATMENT

I give permission for my child to receive medical care at Primary Pediatrics, P.C. I understand that the doctors will use their best judgement in providing care and treatment.

IF I CANNOT BE PRESENT

The following people are allowed to bring my child for medical care if I am not available:

Name: ________________________ Relationship: ____________ Phone Number: _____________
Name: ________________________ Relationship: ____________ Phone Number: _____________
Name: ________________________ Relationship: ____________ Phone Number: _____________

We may communicate with the following individuals regarding patient's condition or course of treatment (parents, other family members). The following people may be contacted as an alternate form of communication in the instance the patient cannot be reached.

Name: ________________________ Relationship: ____________ Phone Number: _____________
Name: ________________________ Relationship: ____________ Phone Number: _____________
Name: ________________________ Relationship: ____________ Phone Number: _____________

ACKNOWLEDGEMENT AND CONSENT FOR TREATMENT

I understand that Primary Pediatrics, P.C. has explained how my health information will be used and protected. My medical information will not be shared with anyone (including family members, spouses, or others) without my written consent, unless required in an emergency.

Patient/Guardian's Name (Printed): _______________________________________

Patient Signature (if 15 years old or older)/Guardian Signature: _____________________________
Date: ____________________________