Partners In Health Pediatrics

Healthcare for Future Generation

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Board Certified Pediatrics

CONSENT TO TREATMENT WITH ACCOMPANIED PERSON

I give consent for _____ to seek medical care
(Please PRINT name of person Authorized)

as indicated below for my child _____ from
(Please PRINT name of Patient)
one of the providers at Partners In Health Pediatrics.

This consent is valid for the following dates: _____ through _____.

Please check (✓) all that apply:

_____ Urgent Sick Care
_____ Emergency Care
_____ Immunizations
_____ Preventative Care

I understand that parent/ guardian is required at, both, the first well exam and first sick visit.

For the reason of insufficient information given by the authorized person for the visit, provider may ask to reschedule the visit with parent / guardian.

- **I understand that I may revoke this authorization at any time except to the extent that treatment has already been taken by relying on it. I understand that this consent to treat authorizes this individual full access to patient's medical records**

Please provide the information about the Picture ID that the individual, you are consenting above, will use as Identification:

Picture ID Description	Number	Expiration

_____ _____ _____
Parent or Legal Guardian PRINTED Name | Signature | Date