HEALTHY KIDS PEDIATRICS

Parent/Guardian Preference Regarding Communication of Health Information

CONSENT TO TREAT

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

I hereby give permission for the following people to obtain medical care for my child:

Both parents can obtain medical care for this patient: ☐ Yes ☐ No

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____I do not wish to give permission for additional family members, relatives or close personal friends to obtain medical care for my child in my absence nor to have access to any information regarding my child's medical condition(s).

_____ _____ _____
Signature of Parent or Guardian | Last 4 digits of SS# | Date Signed

Print Form

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