PEDIATRIC ASSOCIATES

ALTERNATIVE CAREGIVER CONSENT

Consent must be completed by a parent/legal guardian. ***ALL ITEMS MUST BE COMPLETED.***

CAREGIVER INFORMATION		
CAREGIVER:	**RELATIONSHIP TO PATIENT:**	**PHONE NUMBER:**
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Please read carefully before signing below:

- I attest that the above-named individuals are all 18 years of age or older as of today's date.
- I authorize the above-named individual(s) to consent to treatment for my child(ren). This may include, but is not limited to, consent for necessary medications, immunizations, procedures and hospitalizations. Pediatric Associates may relay any medical information, including protected health information, about my child(ren) that is necessary for the above-named individual(s) to provide informed consent to treatment.
- I understand the clinician will communicate his or her findings and treatment plan to the caregiver who brings the child, and under most circumstances a follow-up call to me personally should not be necessary.
- I agree to be responsible for any fees for services requested by the above-named individual(s) when permitted by my insurance carrier(s).
- I agree to hold Pediatric Associates and its staff harmless for any disagreement between the above-named individual(s) and myself regarding treatment decisions.
- I understand that I can revoke this authorization for any or all of these individual(s) at any time.
- **I attest that I am the parent or legal guardian of the following child(ren) and I have the legal authority to make this agreement.**

SIGNATURE:	**PRINT NAME:**	**DATE:**

CHILD(REN) COVERED UNDER THIS CONSENT	
CHILD'S NAME:	**DATE OF BIRTH:**
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