Physicians to Children

PARENTAL/PATIENT CONSENT:

This consent will stay in effect until it is revoked in writing.

____

Patient Name **Date of Birth**

In my absence, I designate the following person(s) to make any medical or surgical decisions or to participate in the treatment of myself or my child. I also designate them to pick up medication samples, written prescriptions, or health information that I have requested from the physician.
Information about me or my child may be disclosed to the following person(s) to the extent of that person's involvement with me or my child's care or payment for care.

I furthermore authorize the medical staff at Physicians to Children to carry out any medical procedures and treatments that are deemed appropriate.

1.____
Name Relationship to Patient

2.____
Name Relationship to Patient

3.____
Name Relationship to Patient

4.____
Name Relationship to Patient

____
Parent/Guardian/Patient Signature

____
Date