CONSENT TO TREAT FORM

(Additional Persons Authorized to Consent for Medical Treatment - i.e., grandparents, aunts, etc.)

Patient: _____ **DOB:** _____

I, _____ [Printed Name], as the parent or legal guardian of the patient named above give my permission for the following individuals:

1. _____ _____
(Name) (Relationship to Patient)

2. _____ _____
(Name) (Relationship to Patient)

to bring my child(ren) to **PRIMARY CARE PEDIATRICS** for:

□ any medical treatment.

□ treatment limited to _____ .

- Additionally, I acknowledge that I am financially responsible for any services rendered.
- Furthermore, I understand that the designated individual bringing my child will receive information from the provider, and ***it is their responsibility to relay this information to me***. Due to time constraints during the clinic day, providers may not be able to re-communicate details of the visit directly.
- I authorize communication and messages regarding appointments, billing information, referrals, prescriptions, or other matters at the contact number(s) provided.
- This agreement remains effective as long as PRIMARY CARE PEDIATRICS provides services to the patient(s) listed on this form. Any future changes to this consent form must be made or revoked in writing.

This permission should also apply to the following children (if applicable):

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Signed: _____ **Today's Date:** _____