Silverdale Pediatrics

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PARENTAL CONSENT FOR TREATMENT OF THEIR CHILD

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that 1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended 2) you consent to treatment at this office, the consent will remain fully effective until it is revoked in writing 3) you have the right, at any time, to discontinue services.

INDICATE YOUR CHOICE BELOW FOR OTHERS TO PARTICIPATE IN CARE:

____If you agree "WITHOUT RESTRICTIONS", the individuals listed below will be considered the primary and/or emergency individuals you wish for us to communicate with regarding your child's care.

___If you prefer "RESTRICTED" access to medical information for others, the individuals listed here will be considered the **only** individuals you wish for us to communicate with regarding your child's care. (If these individuals are **not** available in an emergent situations we may need to use our discretion regarding use and disclosure of your child's medical information.)

PLEASE LIST THE INDIVIDUALS **YOU WISH** TO PARTICIPATE IN CARE:

I consent for treatment of my child as stated above and I agree to give permission to have the following listed persons bring my child into the practice for medical treatment. (A parent or legal guardian must be present to sign for immunizations.)

Name of Child Parent Signature Witness Signature

ADDITIONAL AUTHORIZED INDIVIDUALS INCLUDE:

Name of Individual Phone Number

Name of Individual Phone Number

I agree to permit my child to be treated by the practice as an unaccompanied minor if they come in alone without a parent or other authorized person.

Name of Child Parent Signature Witness Signature