Authorization to Treat Minor Child/Release of Medical Information

FROM: _____

Full Name of Parent or Legal Guardian

I (We) the parents(s) or guardian(s) named above, authorize the following adult caregiver:

NAME: _____

RELATIONSHIP TO CHILD: _____

To decide upon and consent to the rendering of any medical diagnosis and treatment which s/he deems in the best interest of the health and welfare of my child(ren).

To pick up medical records, prescriptions or health forms.

_____
Name of Child/Date of Birth

_____
Name of Child/Date of Birth

_____
Name of Child/Date of Birth

This authorization shall be effective from _____ to _____
Beginning Date Ending Date

_____

Signature of Parent or Legal Guardian **Date**

Child's Pediatrician/Nurse Practitioner/Group:_____

Allergies:_____

Medications:_____

Special Medical Problems/Concerns:_____

Parents/Legal Guardian – PLEASE LEAVE THIS COMPLETED FORM WITH THE ADULT WHO CARES FOR YOUR CHILD(REN) IN YOUR ABSENCE AND HAVE THEM BRING WITH THEM TO EACH AND EVERY VISIT TO The Maryland Pediatric Group, L.L.C./Pediatric Consultants, P.A.