Kids' Corner PEDIATRICS

1114 Bell Shoals Rd
Brandon, FL. 33511
Phone (813) 940-8140
Fax (813) 940-8148

CONSENT FOR TREATMENT FORM

First Name _____ Last Name _____ Date of Birth _____

Please sign ONE of the following options:

I authorize Kids' Corner Pediatrics, PLLC, Dr. Ever I. Rivera, or another covering medical provider to provide care for my child or for myself if I am over the age of 18 or an emancipated minor. In my absence, the following people may also bring my child and provide consent for treatment.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Parent or Legal Guardian Signature _____ Date _____

I authorize Kids' Corner Pediatrics, PLLC, Dr. Ever I. Rivera, or another covering medical provider to provide care for my child. In my absence, and if no other legal guardian is available, I do not authorize that care be provided to my child.

Parent or Legal Guardian Signature _____ Date _____