SUDARSAN R. KAMISETTY, MD., PA
681 W. LUMSDEN RD.
BRANDON, FL 33511

Authorization For Treatment

Patient's Name:

Date of Birth:

I hereby request and give my permission for the physicians of S.R. KAMISETTY M.D. to provide such medical examination and treatment as they deem best for the child's physical or mental welfare.

As parent ( ), or legal guardian ( ), I give my full consent to **SUDARSAN R. KAMISETTY, MD., PA** for office medical examination and treatment of my child. I will notify the physicians' office of any change in the above information or permission.

The undersigned agrees to accept full responsibility for all charges due upon receipt of statement. I direct my insurer and third parties to pay directly to the physicians' office any insurance benefits due for services on behalf of the patient and I hereby assign to the physicians' office all my rights to receive payments from my insurer and third parties for services rendered by the physician's office. I understand I am responsible for any costs incurred in the collection of the patient's account in case of default, including reasonable attorney fees and /or court costs.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural mother, natural father, stepmother/father, referring physician, other physicians involved in the care of my child, and my insurance company(ies).

ARTIFICIAL INTELLIGENCE (AI) USAGE CONSENT

Our practice may utilize secure AI-supported and HIPAA compliant tools for clinical documentation and administrative workflows, and communication assistance. Protected Health Information (PHI) is not shared for this purpose. These tools are used solely to support the delivery and coordination of healthcare services and do not replace the independent medical judgment of the physician or healthcare provider in diagnosing, treating, or managing patient care.

I,_____ parent or legal guardian of the below patient gives permission to _____to seek medical treatment for my child.

Parent's Name: _____
Signature: _____
Date: _____