Physicians to Children & Adolescents

Patient's Name: _____

Date of Birth: _____

HIPAA/CONSENT TO TREAT

We understand that it is not always possible to accompany your child during their office visits. It may be more convenient to have prior authorization in place, so that medical care including immunizations may be delivered to your child in your absence. This authorization will include a phone call to our nurse for medical questions/advice.

If you choose not to pre-authorize treatment in your absence, please be advised that a parent will be required to accompany the child at each office visit, unless other authorization is sent with your child.

☐ I **do not** wish to pre-authorize Physicians to Children & Adolescents to administer care for my child in my absence. I understand that I must accompany my child at every visit unless other authorization is sent with my child.

☐ I authorize Physicians to Children & Adolescents to administer care to my child when accompanied by the individuals listed below. I understand that it is my responsibility to inform the office if this information should change.

Name:	Phone:	Relationship to Patient:
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Parent/Guardian Signature: _____ Date: _____