Alternate Caregiver Consent Form

I authorize the following individual(s) to bring my children to their appointments:

Name:_____Relationship to Child:_____

Name:_____Relationship to Child:_____

Name:_____Relationship to Child:_____

I attest that the above named individuals are all 18 years of age or older as of this date.

I authorize the above named individual(s) to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, immunizations, procedures, and hospitalizations. Pediatric Associates Prof.,LLC may relay any medical information, including protect health information, about my child that is necessary for the above named individual(s) to provide informed consent to the treatment.

I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who bring the child, and that under most circumstances a follow-up call to me personally should not be necessary. I agree to be responsible for any fees for services requested by the above-named individual(s) when permitted by my insurance carrier(s).

I agree to hold Pediatric Associates, Prof.LLC, and its staff harmless for any disagreement between the above named individuals and myself regarding treatment decisions.

I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.

Children Covered by this consent (list full names and dates of birth):

1.)_____

2.)_____

3.)_____

4.)_____

5.)_____

Parent/Guardian's Name:_____ Date:_____

Signature:_____