___________	___________________________________	________	_______ - ______ - _______
(ACCT #)	(PATIENT NAME)	(DOB)	(SOCIAL SECURITY #)

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT OF MINORS

I, the undersigned parent/guardian of ____, authorize the providers and staff of ________________________________, a division of Florida Pediatric Associates to provide medical examination and treatment, as they deem best for the child's physical and mental welfare. I authorize the individual(s) listed below to bring my child to their appointment(s), consent to and discuss their medical examination, diagnosis and treatments that are necessary; up to and including admission to the hospital.

____

NAME ADDRESS PHONE#

____

NAME ADDRESS PHONE#

____

NAME ADDRESS PHONE #

I understand that all of the above named will be required to present valid photo identification at the time they present to the office with my child, my child will not be seen without the presentation of such ID.

This authorization will expire on ____________________ (Note: if left blank this authorization will automatically expire in one year). I understand that it is my responsibility to cancel this consent - in writing - at the time that an individual named above no longer has my permission to consent as described.
Date: _________________

_____________________________________ _________________________________

NAME RELATIONSHIP

____

SIGNATURE

RIGHT TO REVOKE:
CONSIDER THIS NOTE TO BE CONFIRMATION THAT I REVOKE MY PERMISSION FOR _______________________ _________________________,
NAMED ABOVE TO CONSENT TO TREATMENT FOR MY CHILD. THIS IS EFFECTIVEIMMEDIATELY.

____ _________________
SIGNATURE DATE

OFFICE STAFF INITIALS: _______