CONSENT TO TREAT/SHARE MEDICAL INFORMATION

ONLY a Biological Parent or Legal Guardian may complete this form

I, ____, being the (circle one) parent or legal guardian(s) of: ____(child's name) DOB:______________ authorize the following caregivers indicated below to seek care and obtain/consent to:

Routine Medical Care and Treatment ***Emergency Medical Care and Treatment***

Hospitalization ***Immunizations/ Lab and Radiology Testing***

As deemed necessary by a license medical healthcare professional of Southside Pediatrics.

I the undersigned, parent/guardian, consent to the access of my child's protected medical health information in the case of my inability to communicate directly with the office. *I understand that I may revoke or change this consent at any time*. I understand that it is the responsibility of the parent or guardian to maintain this list of names***. Any updates or changes require a new consent form be completed and signed by the biological parent/ legal guardian ONLY.*** I understand that the biological mother and father are always permitted to have access to my child's protected health information unless the parental rights of either the father or mother have been legally terminated by law.

Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend Other: ____

Name____
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O Grandmother O Grandfather O Aunt O Uncle O Guardian
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O Family Friend Other: ____

Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend Other: ____

This will be effective for 12 months or revoked by a parent or legal guardian

____ Date: ______________________

Please Sign and Date

For the privacy and security of our patients, this form will be routinely updated at the request of the parent/guardian or as needed by the providers and staff of Southside Pediatrics.