

ASSOCIATES IN PEDIATRICS, S.C.

Consent to Treat a Minor – Non-Parent Guardian

I, _____ (Parent/Legal Guardian's full name), am the Parent Legal Guardian of _____ (Child's full name), born on ____/____/____ (DOB).

I authorize the following person(s) to seek medical care for my child and to consent to any necessary medical examination, treatment, or procedures as deemed advisable by the healthcare providers at Associates in Pediatrics, S.C.:

Authorized Adult(s):

This authorization includes, but is not limited to, office visits, diagnostic tests, immunizations, and emergency medical care.

Limitations (if any):

I understand that I am responsible for all medical charges incurred for services provided under this authorization, subject to the terms of my insurance coverage.

This consent will remain valid until: _____ (date) Written revocation by me

Parent/Legal Guardian Signature:

Date:

____/____/____

Printed Name:

Relationship to Child:

Phone:

Witness (optional):

Date:

____/____/____