

JDC Pediatrics
Consent to Treat and
Authorization to Disclose Protected Health Information

*Please complete this form so that, in the event you cannot bring your child to an appointment, another adult that you authorize can bring him/her to the appointment and receive information about his/her care. **Step-parents must be listed on this form if there is a possibility that they may bring your child to an appointment.***

I, _____, the parent/legal guardian of
(name of parent/legal guardian)

_____ hereby authorize
(name of child(ren))

the individual(s) below to accompany my child(ren) to visit(s) at JDC Pediatrics, and consent to the examination and/or treatment and disclosure of medical information regarding the initial and/or follow-up care of my child(ren) during the visit(s).

_____ (name of person authorized to bring child) _____ (relationship to child)

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_____ (name of person authorized to bring child) _____ (relationship to child)

This Consent/Authorization:

___ is effective only on _____, 20___

___ is effective from _____, 20___ to _____, 20___

___ is effective until revoked by me in writing

I reserve the right to revoke this authorization at any time by writing to JDC Pediatrics.

Signature of Parent/Legal Guardian

Date