Medical Consent and Verbal Communications

Patient Name: _____ **Date of Birth:**_____

I hereby authorize the following individual(s), other than Biological Parent/Legal Guardian, listed below, to consent to any medical care and treatment needed for my child and provided by any healthcare provider employed with Complete Children's Health, P.C.

Name:	**Relationship to patient:**
_____	_____
_____	_____
_____	_____
_____	_____

I hereby authorize Complete Children's Health, P.C. physicians, nurses and staff to release advice (pertinent to present illness) by telephone for my child to the following individual(s).

Name:	**Relationship to patient:**
_____	_____
_____	_____
_____	_____
_____	_____

I hereby authorize the following individual(s), listed below, to receive protected health information (such as test results or prescription information exclusive of that information further protected by law) from any healthcare provider employed with Complete Children's Health, P.C.

Name:	**Relationship to patient:**
_____	_____
_____	_____
_____	_____
_____	_____

This consent is dated (today's date) _____ and is valid until _____or until revoked, whichever occurs first.

Parent's name (print): _____ **Signature:** _____