

Great Destinations Pediatrics, P.C.

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____

CONSENT FORM FOR MEDICAL CARE

The following persons have my permission to authorize medical treatment if I am not available to give my consent. I understand that it is the parent(s) responsibility to notify Great Destinations Pediatrics of any changes with the list of authorized caregivers in writing.

1. Name _____

Phone _____ Relationship _____

2. Name _____

Phone _____ Relationship _____

3. Name _____

Phone _____ Relationship _____

THIS CONSENT WILL BE VALID FROM _____ TO _____

(Today's Date)

(Future Date)

AUTHORIZATION FOR TEST RESULTS

Parent/Legal Guardian Contact Information (please choose preferred method):

By checking the Abnormal/Normal boxes below you are giving permission to leave a voicemail for your child's test results if you cannot be reached at the time of the call.

Abnormal

Normal

Home Telephone: _____

Cell/Work Telephone: _____

Email Address: _____

Other Contact Name: _____

Relationship: _____

Telephone Number: _____

I UNDERSTAND IT IS MY RESPONSIBILITY TO HAVE THE ORDERED TESTS DONE AND HAVE BEEN EXPLAINED THE IMPORTANCE AND REASONING FOR THE TESTING. THIS AGREEMENT WILL REMAIN IN EFFECT INDEFINITELY.

BY SIGNING THESE AGREEMENTS I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO INFORM GREAT DESTINATIONS PEDIATRICS OF ANY CHANGE OF INFORMATION.

Parent Signature

Date

Witness Signature