East Suburban Pediatrics

Consent for Treatment for child 16 to 17 years of age.

Child's Name: _____ Date of Birth: _____

I, being the parent or guardian of the above named child, do request and authorize any physician or nurse practitioner of East Suburban Pediatrics and his/her staff to perform necessary services for my child which are deemed advisable by the provider whether or not I am present at the actual appointment.

I authorize the following individuals to obtain medical care for this child, in my absence for well or sick care:

_____ _____
Name Relationship to child

_____ _____
Name Relationship to child

_____ _____
Name Relationship to child

I further authorize the release of protected health information, to the individuals named above, regarding the child whose name appears at the top of this document. The following are any exceptions/restrictions to this authorization.

I authorize treatment of the above named child, who is between 16 and 17 years of age for any SICK VISIT without myself or guardian present.

I request this authorization remain in effect until _____ (date), or _____ indefinitely.

I understand that I may revoke this authorization at any time, by submitting a written request.

_____ _____
Signature of Parent or Guardian Printed name of Parent/Guardian