HEALTHY STARTS PEDIATRICS, PC

Authorization / Consent to Treat and Disclose Protected Health Information

I, ________________________________, the parent or legal guardian of the following child (children):
Name of legal guardian

__________________________________ __________________________________

__________________________________ __________________________________

do hereby authorize the individuals listed below to accompany my child or children (above) to the visits at Healthy Starts Pediatrics, and consent to the examination and / or treatment as well as sign for vaccinations and disclosure of medical information regarding the initial or follow-up care of my children during these visits. *Please provide authorization of step parents if applicable.

____ ___________________________
(name of person other than mom / dad bringing child/ren (relationship to child/ren)

____ ___________________________
(name of person other than mom / dad bringing child/ren (relationship to child/ren)

____ ___________________________
(name of person other than mom / dad bringing child/ren (relationship to child/ren)

____ ___________________________
(name of person other than mom / dad bringing child/ren (relationship to child/ren)

THIS AUTHORIZATION / CONSENT IS EFFECTIVE: (select one option below)

_____Only on _________________
(mo/day/year)

_____ Is effective from ________________ to _________________

_____Is effective until revoked by me in writing

I reserve the right to revoke this authorization in writing at any time to Healthy Starts Pediatrics, PC.

____ _______________________
Signature of Parent / Legal Guardian Date