WESTSIDE PEDIATRICS, P. A.

PEDIATRIC CONSENT FOR CARE

For the privacy and confidentiality of our patients, please list the names of individuals who have the right to bring your child into the clinic.

I, _____, give the following people
(NAME OF PARENT / GUARDIAN)
permission to make medical decisions and rights to confidential information (please include the name of the second parent):

Name	Relationship to patient
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

On a new patient visit, the patient must be accompanied by a legal guardian. A picture ID will be checked at each appointment. If one of the above individuals is not listed, then verbal permission by a legal guardian must be given over the phone. Please write contact numbers here of legal guardians:

Name	Phone Number / Location
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

_____ _____
Signature of Parent / Guardian Date