Pediatric Endocrinology of New York PC

Consent to treat a minor

Caregiver other than Parent/Guardian

PATIENT NAME: _____

DATE OF BIRTH:_____

I, _____

FULL NAME OF PARENT OR GUARDIAN

Above guardian of the above name child give the following adults permission to make decisions regarding the necessary and/or routine treatment of my child including but not limited to, examinations, injection, and/or diagnostic procedures. I understand that only myself and those listed below will have the authority to authorize treatment.

_____	_____	_____
NAME (AUTHORIZED CAREGIVER)	**PHONE**	**RELATIONSHIP TO PATIENT**

_____	_____	_____
NAME (AUTHORIZED CAREGIVER)	**PHONE**	**RELATIONSHIP TO PATIENT**

I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from me or treatment could be refused or delayed. I understand that in an emergency, efforts will be made to contact prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached. This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I will notify Pediatric Endocrinology of New York PC of any changes in the above information. I have read all the information on this sheet and certify that the information I have provided here is true and correct to the best of my knowledge.

_____	_____	_____
SIGNATURE	**RELATIONSHIP TO MINOR**	**DATE**