HEALTHCARE STATUS AUTHORIZATION

I, ______________________________ (Parent or legal guardian), hereby give authorization to Angel Kids Pediatrics and its personnel to provide medical care and treatment to patient, listed below; as well as authorization for the release of information concerning the status of my child's care, including laboratory and imaging results to provide medical services and treatment, in my absence, to:

Name: ______________________________ Relationship to Patient: ______________________
Address: ____
Home Phone: (________) ______________________ Cell Phone: (________) ______________________
Authorize access to patient's electronic records? ☐ Yes ☐ No

Name: ______________________________ Relationship to Patient: ______________________
Address: ____
Home Phone: (________) ______________________ Cell Phone: (________) ______________________
Authorize access to patient's electronic records? ☐ Yes ☐ No

Name: ______________________________ Relationship to Patient: ______________________
Address: ____
Home Phone: (________) ______________________ Cell Phone: (________) ______________________
Authorize access to patient's electronic records? ☐ Yes ☐ No

Name: ______________________________ Relationship to Patient: ______________________
Address: ____
Home Phone: (________) ______________________ Cell Phone: (________) ______________________
Authorize access to patient's electronic records? ☐ Yes ☐ No

Patient's Name: ______________________________ **Date of Birth:** ________/________/________

If parents are divorced or separated, please fill out the section below:

Who has primary custody of the child? ☐ Mother ☐ Father ☐ Other: ______________________

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ☐ Yes ☐ No

If yes, please explain and provide a copy of the legal paperwork that supports this restriction:

____
____
____
____

Parent/Guardian Signature: ______________________ Today's Date: ______________________

Print Name: ______________________________

Patients Name: ______________________ Patients DOB: ______/______/______

Gender: ☐ M ☐ F Is Child Adopted? ☐ No ☐ Yes *(if Yes, please provide Court Documents)*

Please note, if Foster / Relative Fostering, we require the following items to be provided to us:

Court Documents, Proper Matching ID and Case Worker Information.