Authorization to Provide Consent for Medical Care to a Minor Child

Completion and signature of this authorization form enables the designated adult to give Good Night Pediatrics medical provider permission to give medical care and treatment to your child when you are unavailable to authorize medical care and treatment, either in person or by phone.
This consent allows for treatment including physician examination, diagnostic testing such as laboratory tests, radiology tests, and necessary treatment including procedures such as laceration repair as determined by the physician.

This consent is in effect for one year after the parent/ legal guardian's signature date or until receipt, in writing, that it has been revoked.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Patient's Name (please print): _____

Date of Birth: _____

Parent/Legal Guardian Name (please print): _____

Signature of Parent/Legal Guardian: _____

Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number of Parent/Legal Guardian: _____

As the designated adult, I agree to determine the need for and to provide consent for the above named child's medical care and any medically necessary procedures that are recommend and provided by the Good Night Pediatrics' physician.

Designated Adult's Name (please print): _____

Designated Adult's Signature: _____

Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____