FOCUS PEDIATRICS
WHERE THE FOCUS IS ON YOU

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AUTHORIZATION FOR CAREGIVER / NON-PARENT CONSENT TO TREAT MINOR

PATIENT INFORMATION

Child's Full Name:	Date of Birth:
Parent/Legal Guardian Name:	
Primary Phone:	

AUTHORIZED CAREGIVER(S)

I/We authorize the following individual(s) to accompany my/our child to medical appointments and consent to routine medical care on behalf of my/our minor child when I/we are unavailable:

Authorized Individual	Phone Number	Relationship to Patient

AUTHORIZATION TO CONSENT FOR TREATMENT

I/We, as the parent(s) or legal guardian(s) of the above-named minor child, authorize the above-listed caregiver(s) to:

- Bring my/our child to appointments at Focus Pediatrics, LLC
- Consent to routine medical evaluation and treatment
- Discuss my/our child's medical condition with healthcare providers as necessary for treatment
- Receive aftercare instructions related to the visit

This authorization includes:
- Sick visits
- Well visits
- Routine testing
- Routine medications
- Routine procedures related to pediatric care

VACCINATION AUTHORIZATION

☐ Authorized to consent for routine immunizations/vaccines ☐ NOT authorized to consent for immunizations/vaccines

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION (PHI)

I/We authorize Focus Pediatrics, LLC to discuss my/our child's protected health information (PHI) with the caregiver(s) listed above as necessary for treatment, care coordination, scheduling, billing, prescription management, laboratory results, immunization records, and follow-up care.

This authorization may include verbal discussions, printed visit summaries, and telephone communications related to the child's healthcare.

I/We understand that:

- This authorization is voluntary.
- I/We may revoke this authorization at any time in writing.
- Revocation will not apply to information already disclosed prior to receipt of written revocation.
- This authorization does not permit disclosure of records otherwise protected by law without additional authorization where required.

LIMITATIONS / RESTRICTIONS

_____ Caregiver may discuss appointments only

_____ Caregiver may NOT receive lab/test results

_____ Caregiver may NOT discuss medications

_____ Other limitations: _____

EMERGENCY CARE

In the event of a medical emergency, I/we authorize Focus Pediatrics, LLC and its healthcare providers to provide emergency medical treatment deemed necessary for the health and safety of my/our child.

INSURANCE / FINANCIAL RESPONSIBILITY

I/We understand that I/we remain financially responsible for all charges incurred for treatment provided to my/our child.

EFFECTIVE DATES

☐ Until revoked in writing

☐ From _____ to _____

☐ For one year from signature date

PARENT / LEGAL GUARDIAN SIGNATURE

Parent/Guardian Name (Please print):	Signature:
Date:	

OFFICE USE ONLY

Staff Initials: _____ Document Scanned into EMR: ☐ Yes ☐ No Date Entered: _____