Eastern Carolina Pediatrics

PATIENT CONSENT FORM

Authorization to Treat Minor Child Not Accompanied by Parent or Guardian

Patient Name: _____ Date of Birth: _____

Your child will not be seen unless he/she is accompanied by a parent/guardian or designated person listed below. If there may be an occasion where your child will be brought in by a relative, friend, sitter, etc., please complete this form for us to keep in your child's record. This authorization will remain in effect until changed by the parent or legal guardian.

Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, xrays, lab work (examples include: throat or nasal swabs, blood draws, cleaning of minor burns, minor suturing of lacerations, removal of simple cysts, and incision and drainage of abscesses). Eastern Carolina Pediatrics also may give immunizations, or intramuscular antibiotics pursuant to the above consent.

I hereby empower and grant the proxy decision maker(s) appointed below, permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnoses and treatment of the minor listed above, and to receive protected health information directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care.

I hereby release, indemnify, and hold harmless Eastern Carolina Pediatrics, P.A. all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual(s) appointed as proxy (listed below) are permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to the authorization. This authorization is valid unless withdrawn in writing and delivered to Eastern Carolina Pediatrics. (Only one parent's signature is required.)

The following person(s), 18 years or older, have my permission to authorize medical services for my child and sign any necessary waivers on my behalf.

Name	Relationship to Child
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Parent/Legal Guardian_____Date:_____