Authorization to Consent to the Medical Treatment of a Child Policy

Garden Pediatrics guards your child's medical information as a requirement of both ethics and law. It is important that we uphold safeguards that ensure the protection of this sensitive information. In the event a parent or legal guardian can not be present at an office visit, Garden Pediatrics will use the authorization of a parent or legal guardian to treat a child. This authorization is given in writing and will be kept on file at Garden Pediatrics.

Notes about the authorization:

- The authorization for treatment is given in writing only by completing the entire attached form.
- If there is a situation where written approval can not be obtained, Garden Pediatrics will accept a verbal authorization ***ONE*** time.
- Garden Pediatrics will refuse to treat if a listed parent or legal guardian can not be reached by the office staff or if a verbal authorization was given previously – no exceptions.
- Authorizations can be received in person, by email to info@gardenpediatrics.com or by fax at 909-792-9395.
- Authorization can be revoked at any time in writing in person, by email to info@gardenpediatrics.com or by fax at 909-792-9395.

Please feel free to contact Garden Pediatrics at any time with questions at 909-792-8866 extension 1 for the Front Office.

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I, _____, make oath and say that I am the lawful guardian of the child(ren) listed below and there are no court orders now in effect that would prohibit us from conferring the power to consent upon another person.

Information of Child(ren)

Name	Birthdate	Address

I hereby authorize and appoint _____ (name) _____(date of birth) as my agent. My agent may

- Discuss diagnosis and treatment
- Consent to Medication and Medication Administration
- Consent to Vaccination Administration
- Discuss Treatment Advice (X-Rays, MRI, Labs, Studies, etc.)
- Complete a Health History Review
- Receive medical information, acting upon medical information (as needed) and communicating medical information to me (as needed)*

* If additional information is needed after the visit is completed, another visit can be scheduled – *this information is not available by phone*

The purpose of this document is to give power and authority to consent to medical treatment for the child(ren) and this power and authority is effective as of _____,20___. I give this consent freely and knowingly in order ot provider for the child and not as a result of pressure, threats, or payments by any person or agency. This consent will remain in effect until (leave blank if indefinite) _____ or by notifying Garden Pediatrics in writing.

NAME: _____

RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH (MUST BE 18 OR OVER): _____

ADDRESS: _____

PRIMARY PHONE: (_____)_____ EMAIL: _____

IN WITNESS WHEREOF, I sign at (city/state)_____.

_____ Signature

_____ Witness Signature

_____ Print

_____ Print

_____ Date

_____ Date

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