Sawgrass Pediatrics

PATIENT INFORMATION				
Last Name:	First:	Middle:	☐ Male ☐ Female	Birth Date:

CONSENT FOR FRIENDS AND FAMILY

In the event that I am in need of medical treatment and unable to consent for my own treatment; or my child is in need of medical treatment and I (or another legal guardian) am unable to bring in my child for treatment:

☐ I, _____, authorize the following person(s) to seek medical treatment for me or my child and to discuss protected health information (PHI) to the extent Sawgrass Pediatrics deems necessary to provide care.
I understand that this might include such information as: diagnosis, prognosis and treatment plans, medication, discharge instructions and plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to the care of the patient. This authorization will remain valid until a new authorization is completed or until written notice to revoke the authorization is received.

1. _____ _____ _____
Name | Relationship to patient | Telephone #

Additionally, the individual named above may:
☐ Pick-up prescriptions ☐ Pick-up documents ☐ Inquire about Referrals
☐ Make/change appointments ☐ Access insurance/billing information ☐ Inquire about test results

2. _____ _____ _____
Name | Relationship to patient | Telephone #

Additionally, the individual named above may:
☐ Pick-up prescriptions ☐ Pick-up documents ☐ Inquire about Referrals
☐ Make/change appointments ☐ Access insurance/billing information ☐ Inquire about test results

3. _____ _____ _____
Name | Relationship to patient | Telephone #

Additionally, the individual named above may:
☐ Pick-up prescriptions ☐ Pick-up documents ☐ Inquire about Referrals
☐ Make/change appointments ☐ Access insurance/billing information ☐ Inquire about test results

Name of Patient or Legal Guardian (print): _____

Signature: _____ Date: _____

OR

☐ I decline to authorize anyone else to seek medical treatment for me or my child.
Name of Legal Guardian (print): _____

Signature: _____ Date: _____