

INFANTS AND CHILDREN, P.A.

Consent by Proxy for Non-Urgent Pediatric Care/Release of Information

Name of Child: _____

Date of Birth/Social Security #: _____

Address: _____

City, State, Zip Code: _____

Contact Number: _____

I, _____ hereby authorize Infants and Children, P.A. to allow the below individuals to assist in the care and treatment of my child in my absence:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

By authorizing the above individuals, I hereby agree to abide by all the financial responsibility associated with the care and treatment of my child. I will be responsible to pay Infants and Children, P.A. for the following:

1. Any co-payments as set by my insurance carrier
2. Any unsatisfied deductible or termination of coverage
3. Any amount my insurance carrier deems my responsibility
4. Any amount considered non-covered by my insurance carrier

Parent/Guardian Signature Date

Parent/Guardian Printed Name

This form gives Infants and Children, P.A., authorization to treat the below patient and release information to persons other than the immediate parent/guardian.