PEDIATRIC CONSENT FOR CARE
TELEPHONE AUTHORIZATION

Authorization to Treat Minor Child when Not Accompanied By Parent or Guardian

ABC Pediatrics of Okaloosa must have permission from a child's parent or legal guardian before providing medical services when someone other than the parent or legal guardian accompanies the child.

Patient's Name: _____ **Date of Birth:** _____

I, _____ **give the following people permission to**
(Name of parent/guardian)

Bring my child/children to ABC Pediatrics of Okaloosa today _____ **to**

Receive medical treatment and to make medical decisions and rights to confidential information during my absence.

The following persons have my permission to authorize medical care for my child.

Name	Relationship

The above individuals will be asked to present their identification at the time of the visit. If permission is granted over a telephone call, it MUST be witnessed by an employee of ABC Pediatrics of Okaloosa.

We certify, _____, **gave verbal permission for the Providers**
(Parent or Guardian's Printed Name)
at ABC Pediatrics of Okaloosa to treat, _____, **on** _____.

Witness Signature _____ **Date** _____

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