Harrisonburg Pediatrics

1947 Medical Avenue
Harrisonburg, VA 22801
(540) 434-3004

9982 Spotswood Trail
McGaheysville, VA 22840
(540) 437-3740

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

I/We designate to _____
(Name(s), address, telephone number)

the approval to obtain, in my/our absence, medical care for my/our child(ren). I/We realize and request that confidential health information be shared with this/these individual(s).

Name(s) and birthdate(s) of child(ren)

_____

Access to certain health information may be restricted. I wish to limit access to my child's medical information as described below.

_____

_____

I wish to restrict this authorization to the following dates: _____

Parent/Guardian signature(s)_____

Date_____

This consent will be considered valid unless revoked in writing. This consent may be revoked in writing at any time. Please understand that we are unable to take back any disclosures previously permitted.

PROVIDER USE ONLY

Acct number _____

Parent/patient or legal guardian has been given a copy of this authorization. _____yes _____no

Staff Signature _____ Date _____

Effective Date 4/14/03