



Somerset Pediatric Group P.A.

CHILD AND ADOLESCENT MEDICINE

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Cynthia Hoens, RNC, CPNP, CSN

Consent to Treat and Authorization to Disclose Protected Health Information

I, _____ the parent/legal guardian of
(name of parent/legal guardian)

_____ hereby authorize
(name of child(ren)/DOB)

the individual(s) below to accompany my child(ren) to visit(s) at SPG, and consent to the examination and/or treatment and disclosure of medical information regarding the initial and/or follow-up care of my child(ren) during the visit(s).

(name of person authorized to bring child)

(relationship to child)

(name of person authorized to bring child)

(relationship to child)

I reserve the right to revoke this authorization at any time in writing to Somerset Pediatric Group.

Signature of Parent/Legal Guardian

Date

Relationship to Child

2345 LAMINGTON ROAD
SUITE 101
BEDMINSTER, NJ 07921
(908) 470-1124

155 UNION AVENUE
BRIDGEWATER, NJ 08807
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