Somerset Pediatric Group P.A.

CHILD AND ADOLESCENT MEDICINE

Consent to Treat and Authorization to Disclose Protected Health Information (Other Than Legal Guardian)

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). **This consent will not be valid for the administration of vaccines.**

____ _______________________
(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