Pediatric Patient Consent Form

Patient Information

Name of Patient:

Date of Birth:

Parent/Guardian Name:

Consent for Medical Treatment

I, the undersigned, am the parent or legal guardian of the above-named minor. I hereby give consent for diagnosis, treatment, and medical procedures as deemed necessary by the healthcare provider for my child. I understand the nature, purpose, benefits, and possible risks involved with the proposed care. All questions regarding the treatment have been answered to my satisfaction.

Release of Information

I authorize health information regarding my child to be released for purposes of medical treatment, billing, and healthcare operations in accordance with applicable privacy regulations.

Emergency Contact

Name:

Relationship:

Phone Number:

Parent/Guardian Signature

Date