



Cary/Apex/Fuquay-Varina Pediatric Centers

Consent for Treatment of Minor Child

I, being the parent or guardian of the following patient(s):

Patient name: _____ **Date of Birth:** _____

do hereby request and authorize any physician or nurse practitioner of the Cary, Apex or Fuquay-Varina Pediatric Centers and his/her staff to perform necessary services for my child/ren which are deemed advisable by the provider, whether or not I am present at the actual appointment.

Below is a list of individuals who have my permission to bring my child(ren) in for treatment:

Patient(s) by him/herself *IF* 16 years or older.

I further authorize the release of protected health information to the individuals named above, regarding the child/ren whose name/s appears atop this document. The following are any exceptions/restrictions to this authorization:

This authorization will remain in effect indefinitely; and will be reviewed annually.

I understand that I may revoke this authorization at any time, by submitting a written request.

Signature of Parent or Guardian

Printed name of Parent or Guardian

Date _____