# 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, in my presence or in the presence of the following individuals.

**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** _____