

PATIENT NAME _____ D.O.B. _____
Last, First, M.I.

1. Please list any persons other than your child’s biological parents, members or other persons, if any, who may accompany your child and consent for treatment, and whom we may inform about your child’s general medical condition or diagnosis (including treatment and healthcare operations):

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

2. Please list the family members or other persons whom we may inform about your child’s medical condition **ONLY IN AN EMERGENCY:**

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

3. Please list the name(s) of persons who are specifically NOT allowed to consent for treatment or be informed about your child’s general medical condition or diagnosis. If a child’s parent is listed please provide us with a copy of legal documents regarding custody or specific restrictions.

Name: _____	Name: _____
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Signature of Patient ≥18 years of Age/Parent/Legal Guardian

Today’s Date

Name of Parent 1/Legal Guardian 1 (Please Print)

Relationship to Patient

Name of Parent 2/Legal Guardian 2 (Please Print)

Relationship to Patient