Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

CONSENT FORM FOR TREATMENT OF MINOR CHILD

MEDICATION AND TREATMENT CONSENT. This Consent Form is intended to confirm written consent for the patient(s) named below (the "Patient") to receive medical treatment at Pediatric Health Care Alliance, P.A. to include services rendered by its employed or contracted providers, and other medical professionals, (collectively "PHCA"). I understand that except as otherwise provided by law, PHCA cannot provide health care services or prescribe medicinal drugs to a minor child without first obtaining written parental or legal guardian consent, as applicable. My signature below hereby confirms my consent for the PHCA and PHCA Providers to provide health care services and prescribe medicinal drugs to the Patient based on the judgment of the PHCA provider, and includes, without limitation, consent for the Patient to be evaluated and treated for medical conditions, including physical or mental health conditions and other sensitive matters, as deemed ordinary and necessary, and advisable, in the judgment of the Patient's PHCA provider.

TREATMENT SERVICES. I understand that medical care and treatment of the Patient that I am consenting to will typically include, as determined by the health care practitioner, ordinary and necessary medical treatment, including a full physical examination including an external genital examination, and the prescribing of medicinal drugs as needed to treat health conditions ("Treatment Services"). By signing below, I acknowledge my consent for the Patient to receive such Treatment Services from PHCA. I acknowledge that this consent specifically expresses my consent for the Patient to receive an external genital exam from a PHCA provider as part of their medical care and treatment. It has been explained to me that I have a choice about the use of Treatment Services at PHCA and other services that may be available or recommended to the Patient during the course of their treatment.

CONSENT TO DISCLOSURE OF HEALTH INFORMATION. To facilitate the treatment services provided by PHCA pursuant to this consent and to coordinate care for the Patient, I hereby authorize and request that copies of prior medical and billing records related to the Patient's treatment services be provided to PHCA. This consent to disclosure specifically includes without limitation, complete psychological and assessment records, most recent plans of treatment, progress summaries, discharge summaries, treatment notes, including mental health information and diagnosis, HIV/AIDS and/or other STD information, substance use or abuse information, genetic information, and any other appropriately related documents or information reasonably requested by PHCA.

ACKNOWLEDGMENT. By signing below, I represent that I am either a parent or the legal guardian of the minor child/children named below, with the legal right to consent to medical treatment and medication prescribing and administration on behalf of the Patient. I consent to Pediatric Health Care Alliance, P.A. physicians, providers, and other employed or contracted medical professionals to provide, solicit and arrange for health care services, and prescribe medicinal drugs when determined necessary in the professional opinion of the treating PHCA provider, to the Patient(s) named below. Additionally, I have listed other people who are authorized to bring my child/children in for medical care and treatment.

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THIS CONSENT FORM HAS BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED.

Child/Children:

Print Name of Minor Child: _____ Date of Birth: _____

Print Name of Minor Child: _____ Date of Birth: _____

Print Name of Minor Child: _____ Date of Birth: _____

Print Name of Minor Child: _____ Date of Birth: _____

I/We authorize the following people to bring my child/children in for medical care and treatment, and to be contacted in case of an emergency:

Name: _____ Phone: ( ) _____ Relationship: _____

Name: _____ Phone: ( ) _____ Relationship: _____

Name: _____ Phone: ( ) _____ Relationship: _____

Name: _____ Phone: ( ) _____ Relationship: _____

Parent/Guardian:

Print Name: _____

Relationship: _____

Signature: _____ Date: _____

For individuals/representatives acting on behalf of the Patient, you must indicate your relationship to the Patient, and provide proof of your authority to act on the patient's behalf (other than natural parents).