PC PEDIATRIC CARE OF ROCKVILLE, P.A.

Consent for Treatment

The following person/persons have my permission to consent to and authorize routine and emergency medical care, treatment and services for my child/children named below. He/she has my permission to receive protected health information relevant to, and for purposes of, his or her involvement in the care of my child/children.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

FOR:

_____	_____
Name	DOB
_____	_____
Name	DOB
_____	_____
Name	DOB
_____	_____
Name	DOB

_____

Parent Name

_____ _____

Parent Signature Date

I understand that it is my responsibility to notify Pediatric Care of Rockville in writing should this agreement change at any time for any reason.

Pediatric Care of Rockville
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