Consent to Treat and Authorization to Disclose Protected Health Information

I,_____the parent/legal guardian of
(name of parent/legal guardian)

_____hereby authorize
(name of child(ren)/DOB)

the individual(s) below to accompany my child(ren) to visit(s) at SPG, and consent to the examination and/or treatment and disclosure of medical information regarding the initial and/or follow-up care of my child(ren) during the visit(s).

_____ _____
(name of person authorized to bring child) (relationship to child)

_____ _____
(name of person authorized to bring child) (relationship to child)

I reserve the right to revoke this authorization at any time in writing to Somerset Pediatric Group.

_____ _____
Signature of Parent/Legal Guardian **Date**

_____
Relationship to Child