Great Destinations Pediatrics, P.C.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____

CONSENT FORM FOR MEDICAL CARE

The following persons have my permission to authorize medical treatment if I am not available to give my consent. I understand that it is the parent(s) responsibility to notify Great Destinations Pediatrics of any changes with the list of authorized caregivers in writing.

1. Name _____

   Phone _____ Relationship _____

2. Name _____

   Phone _____ Relationship _____

3. Name _____

   Phone _____ Relationship _____

THIS CONSENT WILL BE VALID FROM _____/_____/_____ TO _____/_____/_____

(Today's Date) (Future Date)

AUTHORIZATION FOR TEST RESULTS

Parent/Legal Guardian Contact Information (please choose preferred method):

By checking the Abnormal/Normal boxes below you are giving permission to leave a voicemail or secure email for your child's test results if you cannot be reached at the time of the call.

Abnormal	Normal	
☐	☐	Primary Phone Number on File
☐	☐	Secondary Phone Number on File
☐	☐	Email: _____
☐	☐	Other Contact Name: _____
		Relationship to patient: _____
		Telephone: _____

I UNDERSTAND IT IS MY RESPONSIBILITY TO HAVE THE ORDERED TESTS DONE AND **HAVE BEEN EXPLAINED THE IMPORTANCE AND REASONING FOR THE TESTING. I UNDERSTAND GDP CONTACTS ALL PATIENTS WITH NORMAL AND ABNORMAL TEST RESULTS AND IT IS MY RESPONSIBILITY TO CONTACT GDP IF I HAVE NOT RECEIVED THE RESULTS. THIS AGREEMENT WILL REMAIN IN EFFECT INDEFINITELY.**

BY SIGNING THESE AGREEMENTS I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO INFORM GREAT DESTINATIONS PEDIATRICS OF ANY CHANGE OF INFORMATION.

_____

Parent Signature Date