



Consent for Treatment -for caregiver other than parents

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.