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

Permission to Treat

I/We _____ **authorize Pediatric Health Care Alliance, PA**

print name(s) of legal guardian(s)

and its personnel to provide medical care and treatment* (see NOTE below) to my/our child/children, listed below.

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

I/We authorize the following people to bring my/our 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: _____

This Permission to Treat is intended to cover the medical care and treatment of my/our child/children today and in the future until revoked in writing.

_____

Signature(s) of Legal Guardian(s) ***Date***

_____

Primary Phone ***Relationship to patient***

*__NOTE__ – I/we have been informed that medical care and treatment of my/our child/children will typically include, as determined by the health care practitioner, a full physical examination including an external genital examination. Florida Statutes Section 456.51 (Consent for Pelvic Examinations) requires written consent by the patient or the patient's legal representative before a health care practitioner may perform any type of pelvic examination on a patient including an external genital exam. This Permission to Treat expresses my/our consent that an external genital exam may be performed on my/our child/children as part of their medical care and treatment.