703.391.0900

CONSENT TO TREAT

I give consent for _____ to seek medical care as indicated below for my
(Please print name)

child _____ from one of the providers at Fairfax Pediatric Associates, P.C.
(Please print name)

This consent is valid for the following dates: _____ through _____.

I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance on it. I understand that this Consent To Treat authorizes this individual full access to my child's medical records.

_____Urgent Sick Care

_____ Emergency Care

_____Immunizations

_____Allergy Shots

_____Preventative Care

I understand that a parent/guardian is required at both the first sick visit and the first well exam.

If the provider feels this non-parent does not supply sufficient information during a visit, the provider may discontinue the visit, and reschedule the appointment when a parent can be present.

CONTACT INFORMATION: in case the provider needs to speak directly with you.

Mom daytime phone:_____ **Dad daytime phone:** _____

Please provide the number, description and expiration date of the **PICTURE ID** that the individual mentioned above will be using as identification.

_____ (Number) _____ (Description) _____ (Expiration Date)

EXAMPLE:

12345 (Number) VA Drivers License (Description) 01-01-07 (Expiration Date)

_____ (Parent or legal guardian PRINTED name) _____ (Signature) _____ (Date)