Sunshine Pediatrics

AUTHORIZATION FOR MEDICAL CARE

I (We) _____ and _____ authorize Sunshine
PRINT NAME OF MOTHER/ LEGAL GUARDIAN(S) PRINT NAME OF FATHER/ LEGAL GUARDIAN(S)
Pediatrics, LLC and its personnel to deliver medical services to my child(ren):

_____	_____	_____	_____
PRINT CHILD'S NAME	DATE OF BIRTH	PRINT CHILD'S NAME	DATE OF BIRTH
_____	_____	_____	_____
PRINT CHILD'S NAME	DATE OF BIRTH	PRINT CHILD'S NAME	DATE OF BIRTH
_____	_____	_____	_____
PRINT CHILD'S NAME	DATE OF BIRTH	PRINT CHILD'S NAME	DATE OF BIRTH

I (We) authorize the following people to **bring my child in for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence**. This does not allow them to have access to protected health information that is not pertinent to the visit. Please check the boxes to give them additional specific authorizations.*

Name: _____ Relationship: _____ ☐ May pick up prescriptions ☐ May pick up shot records

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*Any other type of documents to be picked up by someone other than the legal guardians listed above must have a separate written consent.

I (We) understand that telephone triage and advice services will ***not*** be extended to the above persons unless it is regarding direct patient care while the child is *in their care*. In the absence of written authorization for medical services, our office will try to reach you for verbal authorization. If, however, we cannot reach you, we will ***not*** refuse to treat your child. This serves as a consent for medical treatment that we deem as medically necessary and appropriate.

Patient/Parent/Legal Guardian Rights:

- I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Sunshine Pediatrics.
- I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Signature of Legal Guardian	Date	Relationship to patient

Printed name: _____