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: ______________________________