CARTERSVILLE PEDIATRIC ASSOCIATES, PC
AUTHORIZATION OF TREATMENT

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Patient confidentiality is important at Cartersville Pediatric Associates. Therefore, we ask that you provide us with the following information:

Please list names of any family members or other parties that you authorize to seek medical attention (over the phone or at a scheduled office appointment), speak to nurses, schedule appointments, pick up prescriptions or forms, and/or receive personal health information concerning your child:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

** Any party **NOT** listed above will **NOT** be able access any of your child's protected health information (including bringing child to appointment or picking up prescriptions or forms) until this authorization is updated by the parent or legal guardian.*

**Photo I.D. will be required from all parties listed above when bringing patient to scheduled appointment or when picking up prescriptions or forms from Cartersville Pediatric Associates*

In the event that I am unable to be reached at the primary phone number listed in my child's record, Cartersville Pediatric Associates may leave the following information on my voicemail (check all that apply):

□ Appointment Reminders □ Test Results □ Referral/Test Information □ Financial Information

By signing below, I understand that a written request must be submitted in order to make changes to, revoke or terminate this authorization.

_____	_____
Signature of Parent/Legal Guardian	Date
_____	_____
Witness Signature	Date

Internal Use Only

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