Advanced Pediatrics

100 East St. S.E. Suite 301
Vienna, VA 22180

CONSENT TO TREAT

I give consent for _____ to seek medical care
(Please print name)

as indicated below for my child _____ from
(Please print name)

one of the providers at Advanced Pediatrics.

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

Please check ✓ those that apply:

_____ Urgent Sick Care

_____ Emergency Care

_____ Immunizations

_____ 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.

**** 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. ****

Please provide the description, name, and expiration date of the PICTURE ID that the individual, you are consenting above, will be using as identification.

Description	Number	Expiration Date

Example:

Description	Number	Expiration Date
VA DRIVER'S LICENSE	T49-22-5555	08-27-2012

_____ _____ _____

Parent or Legal Guardian Printed Name | Signature | Date