

CARROLL CHILDREN'S CENTER

Peter K. Chung, M.D.
Cynthia Newton, PA-C
Angela Masters, CPNP

Yasmeen Abernathy, M.D.
Shannon Gibbons, PA-C Sarah Letos, PA-C

CONSENT FOR TREATMENT

I hereby authorize the care providers of Carroll Children's Center, and such assistants as may be designated, to perform usual sick and/or well care; including all necessary injections, tests, administration of treatment, screening, advice and follow-up care, for the welfare of:

NAME OF PATIENT DOB

NAME OF PATIENT DOB

NAME OF PATIENT DOB

NAME OF PATIENT DOB

NAME OF PATIENT DOB

NAME OF PATIENT DOB

My physician has offered to answer all inquiries concerning the proposed treatment/procedure. I understand that I am free to withhold or withdraw consent to the proposed treatment/procedure at any time. I hereby certify that I am eighteen years of age or older, or that I am the responsible legal guardian of the above-named patient.

Signature of person giving consent Relationship to patient Date

COMPLETE ONLY IF APPLICABLE:

I hereby authorize the persons listed below to bring the above-named patient to this office for the care described above.

Caretaker's name & relationship

Caretaker's name & relationship

Caretaker's name & relationship

Caretaker's name & relationship

Parent's/Guardian's Signature

For EMERGENCY in absence of parents, contact _____

Relationship to patient _____ Phone # _____