Physicians' Primary Care of Southwest Florida

Child's Name _____ DOB _____

Authorization for Use and Disclosure of Protected Health Information and Consent for Treatment of a Minor without Parent Present (HIPAA)

I give permission for my child to be medically evaluated and treated at Physicians' Primary Care of SWFL in my absence. I understand that it may be necessary to perform diagnostic tests (i.e. cultures and labs) in the course of the evaluation. I accept responsibility for physician charges and laboratory fees. The individuals listed will have access to my child's medical information including but not limited to information in the chart and picking up prescriptions or forms.

This consent applies to:

1. Complete physician check-up (including blood and urine samples)
2. Hearing, vision, scoliosis and blood pressure screening
3. Immunizations
4. First aid and emergency care
5. Prescription and treatment for illness
6. Referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

My teenage child may come in for treatment without a parent present _____yes _____no

If there are any services that you do not consent to in your absence, please list:

_____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

Parent or Guardian Signature _____ Date _____

****This form is only authorized for 1 year from the date above. ****

5/9/17