

Village Pediatrics & Internal Medicine



300 Market St. Ste. 112
Chapel Hill, NC 27516
Phone: 919-969-9611
Fax: 919-969-9615

& Takes a Village..

Consent for Treatment of Minor Child

Printed Patient Name

Patient's Date of Birth

I, _____, being the parent or guardian of the above named child, do hereby request and authorize any physician or nurse practitioner of Village Pediatrics & Internal Medicine of Chapel Hill, PA and his/her staff to perform necessary services for my child which are deemed advisable by the provider, whether or not I am present at the actual appointment.

I authorize the following individuals to obtain medical care for this child, in my absence:

Printed Name

Relationship to minor patient

Printed Name

Relationship to minor patient

Printed Name

Relationship to minor patient

Printed Name

Relationship to minor patient

I further authorize the release of Protected Health Information to the individuals named above, regarding the child whose name appears atop this document. The following are any exceptions &/or restrictions to this authorization:

I request this authorization remain in effect until _____ or _____ indefinitely.
Future Date Initials

I understand that I may revoke this authorization at any time via written request.

Today's Date

Printed name of Parent or Guardian

Signature of Parent or Guardian

I acknowledge that I have received Notice of Privacy Practices _____
Initials