A Division of Florida Pediatric Associates, LLC
6150 Metrowest Blvd., Suite 105
Orlando, Florida 32835
Ph: 407-897-3544 Fax: 407-897-4016
Toll free: 1-866-356-3075

PERMISSION TO TREAT

I, ______________________________________ (print name of legal guardian) hereby authorize Florida Child Neurology, PLLC, and its personnel to provide medical services, such as medical examinations and treatments, as they deem best for the child's physical or mental welfare.

Print Child's Name: ________________________________ DOB: _____/_____/_____ SS#: _____-_____-_______

I authorize the following person(s) to bring my child in for treatment and to discuss necessary treatments, medications, and to even authorize any tests or labs, that may be deemed necessary by the medical staff of Florida Child Neurology—up to and including admission to the hospital.

Name: ___________________________________ Mother: ____

Name: ___________________________________ Father: ____

Name: ___________________________________ Relationship to Patient: ______________________________

Name: ___________________________________ Relationship to Patient: ______________________________

** All of the above will provide identification to be placed in the patient's medical chart.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to biological parents, step-parents, referring physicians, other practitioners, and my insurance company.

I have been advised and understand the Notice of Privacy Practices of Florida Child Neurology, PLLC.

____ ___________________

Signature of Legal Guardian Date

Relationship to Patient: ____