THE pro • vi • sion

1. n. School and Family Counseling Center, Inc.
2. v. Equipping One for Life's Journey

Parent/Guardian Preference Regarding Communication of Health Information
CONSENT TO TREAT

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

I hereby give permission for the following people to obtain medical care for my child:
Both parents can obtain medical care for this patient:

- ❑ Yes
- ❑ No

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

_____I do not wish to give permission for additional family members, relatives or close personal friends to obtain medical care for my child in my absence nor to have access to any information regarding my child's medical condition(s).

_____ _____

Signature of Parent or Guardian Date Signed