Consent for Child's Assessment and Medical Information

As the legal guardian / custodian, I Consent to the Medical Evaluation for:

_______________________________ _______________________________
(Name) (Relationship)

of _____/______ of age, hereby voluntarily consent to the rendering of care, including diagnostic procedures, by
(Yrs / Months)

authorized members of Matrix Medical Network staff or their designees, as may in their professional judgment be necessary. This care will be according to the standards of care within the community and the realm of medical necessity as deemed appropriate by the provider.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

We/I hereby give our (my) consent to Matrix Medical Provider who will care for our (my) child and to arrange for routine, or emergency medical care and treatment necessary to preserve the health of our (my) child.

Name of guardian: ___________________________ ______________________________

Address: ____

City: ____________________________, State:_______, Zip:__________

I have read this form and certify that I understand its contents.

Signature: ____ Date: ___________________________
Mother, Father or Legal Guardian

Witness: ____ Date: ____________________________

In case of emergency I can be reached at: ____

____

____

In the Absence of the Parent of Guardian, advance consent is required. See next page.

(In the Absence of the Parent of Guardian)

CHILD'S NAME: ____ DOB ___________________________AGE ______

CHILD'S NAME: ____ DOB ___________________________AGE ______

CHILD'S NAME: ____ DOB ___________________________AGE ______

CHILD'S NAME: ____ DOB ___________________________AGE ______

I (We) the parent (s) or legal guardian (s) authorize the individual (s) named below to act in my (our) behalf with the full authority to grant permission for any medical treatment. In addition, the provider is hereby authorized in an emergent situation to perform whatever acts that in his/her professional opinion that is in the best interest of the above-mentioned child. I understand that the provider may request to contact the parent/ guardian prior to providing medical treatment even though this consent is presented.

ADULTS THAT MAY CONSENT FOR MEDICAL TREATMENT IN MY (OUR) ABSENCE:
(Authorized individual(s) should also be recorded in CHA)

Name: ____ Phone #: ____________________________

Address: ____

Name: ____ Phone #: ____________________________

Address: ____

This consent form will be in effect for 12 months from signing or less time if specified: _________

AUTHORIZED BY: (Both parents signature preferred, but not required)
By signing below, I certify that I am the legal parent or guardian of the child identified above and am acting within my authority in signing this Pediatric Consent form.

Mother (Printed): ______________________________________Father (Printed): _____________________________________

Signature: ____Signature:____

Date: ____Date: ____

Phone #: ____________________________ **Phone #:** ____________________________

Or

Legal guardian (printed):____

Legal guardian signature: _____________________________________Date: ____

Phone #: ____________________________ **Phone #:** ____________________________

ANY CHANGES TO THIS CONSENT MUST BE MADE IN PERSON

COMPLIANCE HOTLINE: 1-800-863-6599