

River's Edge Pediatrics, Inc.

A Parent/Guardian or otherwise authorized requester must complete this form. Please select one:

CONSENT TO TREAT FOR SAME DAY APPOINTMENT

I, _____, am unable to accompany my child _____
(Name of Parent/Legal Guardian) (Name of Child)
to his/her appointment on _____
Date and Time of Appointment

Therefore, I give my permission for:

- Patient to seek medical care from River's Edge Pediatrics, Inc.
- _____ to bring patient to seek medical care from River's Edge
(Printed name of person bringing patient)
Pediatrics, Inc.

I understand that this authorization is only for the specified date and time of appointment listed above.

Signature of Parent/Legal Guardian

Date Signed

Time

CONSENT TO TREAT FOR ONGOING/CONTINUED CARE

I, _____, grant permission for the person (people) listed below to
(Name of Parent/Legal Guardian)
act on my behalf seeking medical care from River's Edge Pediatrics, Inc. for my child in the event of my
absence.

Person/Persons:

Name: _____

Relationship _____
Relationship _____
Relationship _____

I understand that this consent may be revoked by me at any time, by notifying this practice in writing. If I should decide to change or amend the names of the entities, I will need to complete a new form, provided by this practice, and all previous information will be null and void from the new date forward.

Signature of Parent/Legal Guardian

Date

Printed Name of Parent/Legal Guardian

Date

The individual named above has appeared before me in person and acknowledged the due execution of this request.

Printed Name of Notary Public

Date Commission Expires

Original Signature of Notary Public

Date of Appearance

AFFIX NOTARY SEAL