PARENTAL MEDICAL CONSENT FORM FOR A MINOR CHILD

Please circle one:
I have the legal right to consent to medical and surgical treatment because:
(a) I am the patient
(b) I am the parent/guardian of the patient(s) who is/are listed below.

General Consent for Treatment

I voluntarily authorize and consent to the medical care, treatment, and diagnostics tests that the providers of Lighthouse Pediatrics of Naples and their designated associates or assistants believe are necessary. I understand that by signing this form, I am giving permission to the doctors, nurses, physicians assistants, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent. _____ (**Please Initial)**

Voicemail/Text Notifications/Triage Calls

As a service to our patients, Lighthouse Pediatrics of Naples provides courtesy appointment reminder calls/texts and possibly other important calls that may be placed using a pre recorded auto messaging system. The information may include protected health information. We also may provide triage calls to our patients regarding patient care as well as parent concerns. Our Medical Assistants may also leave voicemails, however no patient test or lab results will be left using this form of communication. By initialing below, you consent to receiving such calls/texts at the cell phone number you have provided to our office. _____ (**Please Initial**)

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize Lighthouse Pediatrics of Naples to allow E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as a physician/patient relationship exists, or until I withdraw my consent. _____ (**Please Initial)**

(TURN OVER TO COMPLETE)

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it. _____ (**Please Initial**)

Please list ALL Children's names:

Patient's Full Name: _____ DOB:_____

Patient's Full Name: _____DOB:_____

Patient's Full Name: _____DOB:_____

Patient's Full Name: _____DOB:_____

Please print the name of the Patient's parent/guardian *if patient is under 18:*

_____

Relationship of Patient's parent/guardian *if patient is under 18:*

_____

Signature of Patient's parent/guardian:

_____

Date: _____