

Medical Care Authorization

I _____, authorize the following individuals to seek medical care including treatment and performance of in-office diagnostic procedures for my child. By signing this form, I am granting consent to Cornerstone Pediatrics to disclose my child's protected health information for the purpose of treatment to those listed on this form during the child's office visit in my absence. However, the child's medical records or other forms of written record (with the exception of prescriptions and referrals) will not be released and will follow established protocol.)

As a primary signor of this form, I have the right to change this consent at any time in writing, except to the extent it may have already been used to disclose my child's protected health information in reliance to my consent. If I choose to change this authorization, I may do so by contacting this office at 772-785-8989, and requesting a new form from this office or by sending a letter of inquiry with the required information, to the patient's record pertaining to medical care authorization which is to be changed.

The "name and signature of the parent or legal guardian that is completing this document" on this new authorization must be a primary signor as indicated on this form. If different they must show proof of legal guardianship for a new form to be effective. I understand it is my responsibility to keep this form updated in order for it to be executed properly.

I acknowledge the information supplied in this form is true to the best of my knowledge. I understand and agree that any false information, that hinders the procurement of funds for payment of services rendered, or that impedes the ability for medical service(s) and/or diagnosis to be appropriately given for the betterment of the patient involved, may be used against me should legal proceedings be sought.

Name and signature of the parent or legal guardian that is completing this document:

Your Name: _____ Signature: _____

Patient's Name: _____ Patient's Date of Birth ____ - ____ - _____

Persons authorized to seek medical attention for my child are:

(Please include Driver's License number in the ID section if available, otherwise leave blank.)

Primary's Name: _____ Relationship: _____ ID Presented: _____

Primary's Name: _____ Relationship: _____ ID Presented: _____

Name: _____ Relationship: _____ ID Presented: _____

Name: _____ Relationship: _____ ID Presented: _____

Name: _____ Relationship: _____ ID Presented: _____

Cornerstone Pediatrics

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