CONSENT FOR TREATMENT OF A MINOR

_____	_____
Patient Name	Patient Date of Birth

In the event that I am unable to be present with my child during a clinic visit, I authorize the following legally and medically competent adult(s) to serve as my proxy at the time of visit.

By signing this form, I also give my permission to ***Bailliard Henry Pediatric Cardiology, PLLC*** to perform the necessary services as deemed advisable by the physician and to share protected health information with the authorized listed adult(s).

As in any visit, a valid health insurance card must be brought and copayment will be expected at the time of visit.

Below is a list of individuals who have my permission to bring my child for treatment, and who will be asked to present a government issued ID at the time of visit.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Name	Date of Birth	Relationship to Patient

_____	_____
Signature of Parent/Guardian	Date
_____	_____
Witness	Date

Authorization is in effect until revoked by parent or guardian