Warwick PEDIATRICS

PERMISSION FOR OUTPATIENT MEDICAL TREATMENT AND ACKNOWLEDGEMENT FORM

Patient _____ Date _____

Permission is hereby granted to the physician and other professionals of Warwick Pediatrics to provide routine medical care for the above named patient, including assessment, diagnostic testing and rendering treatment.

This consent shall remain in effect for the above mentioned patient unless withdrawn in writing.

This consent does not cover evaluation and treatment associated with motor vehicle accident or work related injury or illness that is covered by no-fault workers' compensation insurance. Additional consent is required for that type of care.

I hereby certify that I have read or have had explained to me the above permission and acknowledgement statements:

_____
Patient

_____
Relationship to Patient

_____
Authorized Representative *(see below)*

The above permission is to be signed for all patients and maintained in the medical record.

It should be signed by the parent, legal guardian, next of kin, or legally appointed individual who represents the patient when the patient is:

1. Incompetent by judicial finding
2. Physically incapable
3. Mentally lacking capacity
4. A minor less then 18 years of age UNLESS:
   - *Patient is pregnant*
   - *Patient is parent*
   - *Patient has been legally married*

In addition, an individual less than 18 years of age may give consent for evaluation and treatment of a sexually transmitted disease.