Springville Pediatrics

CONSENT TO RECEIVE CARE WITH ALTERNATE CARETAKER

Patient Name: _____ Date of Birth _____/_____/_____

I give permission to _____,

_____, to bring my child for medical care.
Relationship

Including: ❑ well child care *(please check all that apply)*

❑ sick child care

❑ immunizations

❑ other _____
please describe

Expiration Date _____/_____/_____

Patient Signature _____ Date _____/_____/_____

Witness _____ Date _____/_____/_____

Note: Certain information is considered to be sensitive in nature and as required by law may not be released to anyone except the patient!