314 Main Street Suite D
P.O. Box 1400
Monticello, MS 39654
(601) 587-4304 Main
(601) 587-4515 Fax

Caring Hands
Children's Clinic, LLC

List Child/Children's Names and Birthdays:

_____
_____
_____

My signature below authorizes the following persons to bring my child/children in for treatment at the Children's Clinic without my presence:

Person's Name	Relationship to Patient	Phone Number

I give permission to the practitioners at Caring Hands Children's Clinic and their staff to disclose those listed above my child's Protected Health Information (PHI) including but not limited to treatment, testing, diagnosis, and laboratory tests (including picking up prescriptions and completed medical forms). I understand that those listed above may make decisions regarding the recommended treatment and testing by the practitioner and must be responsible for relaying details of the services rendered during my child's visit back to me. I further understand that I may revoke this authorization at any time with written notice to Caring Hands Children's Clinic, LLC.

Guarantor's Signature: _____ Date: _____

Guarantor's Name (Print): _____

Relationship to Patient: _____

Witness: _____ Date: _____

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CONSENT FOR TREATMENT

The undersigned hereby authorizes _____ as our agent to
Grandparent, nanny, etc
give consent to medical treatment by any licensed provider at Caring Hands Children's Clinic for

_____(patient name), my minor child. Such treatment is deemed necessary by such provider and I cannot be reached within a reasonable time, by reason of absence from the community or otherwise. Such consent may include, but is not limited to, administration of necessary local anesthetics, medical treatment, tests, X-ray examinations, injections or drugs and the performing of whatever procedures may be deemed necessary or advisable. Further, consent is granted to said provider to exercise his or her discretion in authorizing the disposal of any severed tissue or members.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide the authority to consent thereto as our said agent and the above-named child's attending physician, in the exercise of his or her best judgment, may deem advisable.

This authorization shall remain effective unless revoked in writing by the undersigned.

_____ _____

Signature of parent/legal guardian Date