HOLYOKE PEDIATRIC ASSOCIATES

150 Lower Westfield Rd, Holyoke, MA, 01040
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Consent for Non-Urgent Medical Pediatric Care

Under the Health Insurance Portability and Accountability Act (HIPAA) instituted April 20, 2005, we must always protect the privacy and security of patient information for our patients.

If you cannot accompany your child (anyone under 18 years old) in the future, we must ask that you sign a consent form stating that you are giving permission for Holyoke Pediatric Associates to treat and make medical decisions for your child.

Authorization

In my absence, I _____, parent/guardian who has legal custody of my child, _____ and whose date of birth is _____, authorize the following individual, (name & phone number) _____, to provide consent to Holyoke Pediatric Associates to render care under the supervision and advice of a Pediatrician or other medical care professional.

Please initial below with the items you wish to allow the above individual to consent to:

Initial for consent	Scheduling Appointments
Initial for consent	Medical exams and treatments
Initial for consent	Surgical exam and treatments
Initial for consent	Laboratory tests
Initial for consent	Immunizations
Initial for consent	Triage advice by telephone
Initial for consent	Telephone communication when parent/guardian is unavailable

By signing this form, I am agreeing for the above individual to consent for my child from:

Date: _____ to Date: _____

This consent may be removed at any time by the parent/legal guardian if requested in writing.

PARENT/LEGAL
GUARDIAN SIGNATURE: _____ DATE: _____

Revised Dec 2023