Consent to Care

BEE WELL PEDIATRICS CONSENT TO CARE

Parent/legal guardian name:

I am the parent/ Legal guardian of:

patients DOB:

I authorize,

relative/friend:

Please initial any or all that apply:

- [ ] Make health-related decisions pertaining to the patient mentioned above
- [ ] Schedule appointments/Bring my child to appointments
- [ ] Have access to Health information: Test Results, Appointment information
- [ ] Have access to Financial/Billing information

If you have any questions, please feel free to reach me at 719-719-1233

Untitled | Date | Todays Date: