Pediatric Cardiology Care

PATIENT CONSENT TO TREAT

I have the legal right to consent to medical treatment because (a) I am the patient, or (b) I am the parent/guardian of the patient. All references to "patient" or "my" in this document refer to:

_____(name of patient).

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Pediatric Cardiology Care and their designated associates or assistants believe are necessary for the patient. I consent to the taking of photographs, diagnostic images and films related to the care and treatment of the patient. I understand that by signing this form, I am giving permission to the doctors, medical assistants and other health care providers at Pediatric Cardiology Care to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

By signing below I acknowledge that I have read and understand the contents of this form, and that I have had an opportunity to discuss my or my child's care with a health care provider at Pediatric Cardiology Care. I have had an opportunity to ask questions about this form and the care provided by the health care providers at Pediatric Cardiology Care.

Patient's Name:	
Patient's Date of Birth:	
Parent/Representative's Name:	
Relationship to Patient:	
Parent/Representative's Signature:	
Date Signed:	