



Douglass M. Hasell, MD, FAAP  
Diplomate  
American Board of Pediatrics

Thuy T. Pham, MD, FAAP  
Diplomate  
American Board of Pediatrics  
International Board Certified  
Lactation Consultant

Christopher Pope  
Board Certified  
Pediatric Nurse Practitioner

Sheridan Hernandez, MD,  
FAAP  
Diplomate  
American Board of Pediatrics

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Patient Name

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Date of Birth

## Authorization to Treat a Minor

I hereby request and give my permission for the physicians of The Pediatric Specialists Medical Group to provide medical services including examination and treatment (except for immunizations) that they deem best my child's (16 and above) physical or mental welfare.

As the parent ( ), or legal guardian ( ), I give full consent to doctors Hasell, Pham, Hernandez, or Chris Pope ARNP for office medical examination and treatment for my child (16 and above) in my absence. I will notify the physician's office of any change in the above information or permission.

As parent/guardian, I understand that each appointment must be confirmed via phone with me 1-2 days prior to the appointment and that if the appointment is not confirmed then it will be necessary to reschedule to a later date. I further understand that the office staff must speak directly with me to confirm that my teen will be coming to his/her appointment without a parent/guardian and that I am aware of the reason for said appointment.

The undersigned agrees to accept full responsibility for all charges due upon receipt of statement. I direct my insurer and third parties to pay directly to the physicians' office any insurance benefits due for services on behalf of the patient and I hereby assign to the physicians' office all my rights to receive payments from the insurer and third parties for services rendered in the physician's office. I understand I am responsible for any costs incurred in the collections of the patient's account in case of default, including reasonable attorney fees and/or court costs.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural mother, natural father, stepmother, stepfather, referring physician, other physicians involved in the care of my child, and my insurance company/companies.

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Signature (Parent / Guardian)

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Date

I, \_\_\_\_\_, Parent, or legal guardian, of the above patient gives permission for The Pediatric Specialists Medical Group to treat my teenage child in my absence.

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Signature of Notary

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Notary Stamp