DELEGATED CONSENT FOR TREATMENT & SHARING OF HEALTH INFORMATION

Patient : ____ Date of Birth: ____________________

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We know you may not always be able to bring your child for a check-up or a minor illness. Children may sometimes come with a relative, close friend, or daycare provider. We want to work with you to take care of your children.

- By marking "NO", you are telling ***Child & Teen Wellness Center*** that you want your child(ren) only seen when a parent or legal guardian is present.
- By marking "YES", you give ***Child & Teen Wellness Center*** permission to see your child(ren) for well care, immunizations or for minor illnesses when another adult brings them. Your signature means that you understand what you are agreeing to and your questions have been answered.

( ) NO, *I do not want another adult to bring my child(ren) to your office*

( ) YES, *I want another adult to be able to bring my child(ren) to your office.*

The adult who brings your child should know how to reach you by phone.

Child & Teen Wellness Center provides ongoing medical care to my child. I give permission to provide care when I send my child(ren) to this office with another adult. If a serious problem is identified, ***Child & Teen Wellness Center*** may provide the urgent, needed care while making efforts to contact me. I understand that I am responsible for speaking with the provider and/or accompanying adult to receive information pertaining to the office visit. This form will remain in effect until ***Child & Teen Wellness Center*** is notified in writing of any changes.

We will only discuss your child's/children's health with the people listed below:

Name: ____________________________________ Relationship to child: _____________________

Phone: __________________________________

Name: ____________________________________ Relationship to child: _____________________

Phone: __________________________________

Please Note:

According to Maryland law, we are authorized to see children under 18 years of age without parental consent for the following: Drug/alcohol use, mental health problems, sexually transmitted diseases, contraception, pregnancy, rape, or sexual abuse. If you have any questions, please speak with your child's provider.

Parent/ Guardian Signature: ____ Date: ______________

1/13/21