WAIVER FOR TREATMENT

SEE PAGE TWO FOR FORM

We would prefer to have the patient/parent/guardian sign this form and return to us. If a verbal authorization (i.e., phone authorization) is required, please contact our office at **(402) 991-5690.**

This form is used to:

- Authorize a parent or legal guardian to authorize treatment of a minor child, handicapped child or adult without the presence of the parent or legal guardian. That is, it authorizes the patient to receive care alone or in the presence of another person, such as a caregiver, family member, grandparent, etc.

- Authorize Beyond Care Pediatrics, LLC. to provide access to the Protected Health Information of a patient by someone other than the patient or parent/legal guardian. For example, it may be used to authorize access to the patent's Protected Health Information by a step-parent, patient's fiancé, patient's grandparent, adult child's parents, etc.

WAIVER FOR TREATMENT

PLACE PATIENT LABEL HERE

Date _____ /_____ /_____

I, _____, hereby give the following authorization(s) as indicated by my signature and initials in the applicable blanks below:

____ _____, (DOB ___ /___ /___) may obtain medical services at Beyond Care Pediatrics, LLC by its physician(s) or designees without my presence.

____ I agree to authorize_____ to obtain medical care
(Name/Relationship)
and treatment from the physician(s) or designees of Beyond Care Pediatrics, LLC for _____ (DOB ___ /___ /___) in the event I am unavailable to accompany them for treatment.

____ I agree to authorize_____ to obtain
(Name/Relationship)
access to the Protected Health Information (PHI) of my minor child,
_____(DOB ___ /___ /___).

I understand by signing this authorization, I confirm I am the responsible legal party and I am able to execute this document on behalf of the patient named herein. I understand any change to this authorization must be in writing. In the event of revocation, the person executing revocation is required to notify the applicable parties (i.e., the other parent, guardian, etc.). Beyond Care Pediatrics, LLC. is not responsible to execute notification of revocation.

_____ _____ /_____ /_____
Signature/Relationship (Patient, Parent, Guardian, etc.) Date

_____ _____ /_____ /_____
Witness Signature Date

Verbal Authorization

The above statement has been read to the named party and agreement of the statement by the named party has been witnessed by:

_____ _____ /_____ /_____
Witness Signature Date

_____ _____ /_____ /_____
Witness Signature Date