CAPITAL DISTRICT PEDIATRIC CARDIOLOGY ASSOCIATES

CONSENT FORM FOR THE TREATMENT OF A MINOR PATIENT

I _____, the parent or legal guardian of _____, date of birth_____, hereby grant my permission for _____, who is caring for my child during my absence, to seek medical care and make treatment decisions for the above-named minor. I understand that I will be responsible for full payment for this visit as described in the CDPCA "Patient Financial Policy and Responsibility for Payment" guideline.

_____ _____
Signature of parent or legal guardian Relation to minor patient

_____
Date

In the absence of a parent or legal guardian signature, the following witnesses obtained phone consent from the legal guardian listed above.

_____ _____
Signature of witness # 1 Date

_____ _____
Signature of witness # 2 Date