Premier Choice Healthcare

1832 Hospital Drive Jackson, MS 39204
Office: (601) 371-8883
Fax: (844) 318-4882

CONSENT FOR TREATMENT

The undersigned hereby authorizes _____ as our agent to give consent to medical treatment by any licensed provider at Premier Choice Healthcare for _____ (patient name), my minor child. Such treatment is deemed necessary by such provider and I cannot be reached within a reasonable time, by reason of absence from the community or otherwise. Such consent may include, but is not limited to, administration of necessary local anesthetics, medical treatment, tests, X-ray examinations, injections or drugs and the performing of whatever procedures may be deemed necessary or advisable. Further, consent is granted to said provider to exercise his or her discretion in authorizing the disposal of any severed tissue or members.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide the authority to consent thereto as our said agent and the above-named child's attending physician, in the exercise of his or her best judgment, may deem advisable.

This authorization shall remain effective unless revoked in writing by the undersigned.

_____

Signature of parent/legal guardian Date

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List Child/Children's Names and Birthdays:

_____
_____
_____

My signature below authorizes the following persons to bring my child/children in for treatment at Premier Choice Healthcare without my presence:

Person's Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give permission to the practitioners at Premier Choice Healthcare and their staff to disclose those listed above my child's Protected Health Information (PHI) including but not limited to treatment, testing, diagnosis, and laboratory tests (including picking up prescriptions and completed medical forms). I understand that those listed above may make decisions regarding the recommended treatment and testing by the practitioner and must be responsible for relaying details of the services rendered during my child's visit back to me. I further understand that I may revoke this authorization at any time with written notice to Premier Choice Healthcare.

Guarantor's Signature: _____

Date: _____

Guarantor's Name (Print): _____

Relationship to Patient: _____

Witness: _____

Date: _____