Patient Registration & Consent

Fort Payne Pediatrics
1359 Old Water Works Rd SW • Fort Payne, AL 35968-3347 • (256) 997-5900

Delegation of Consent for Minor Children & Acknowledgment of Receipt of Privacy Practices

I, _____, authorize Fort Payne Pediatrics, LLC and its personnel to deliver any and
Print Name (Patient or Guardian if under 14)
all medical care and attention which is deemed necessary and appropriate by a healthcare provider licensed in the state of Alabama to me and/or child(ren) listed below. This consent includes, but is not limited to, medical treatment, surgical intervention, elective procedures, and emergency care. This authorization shall be valid until I withdraw my delegation of consent.

(Please Print**)**

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

The following section must be completed if the patient is under the age of 14:

I, _____, authorize the following people to bring my child(ren) in for treatment
Print Name of Biological Parent or Legal Guardian
and to consent to any and all medical care and attention which is deemed necessary and appropriate by a healthcare provider licensed in the state of Alabama. This consent includes, but is not limited to, medical treatment, surgical intervention, elective procedures, and emergency care. This delegation shall be valid until I withdraw my delegation of consent.

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Please note: If patient is under the age of 14, the individual listed above are the **ONLY** people (other than biological parents or legal guardians) authorized to bring your child(ren) to the doctor.

I have reviewed this office's Notice of Privacy Practices which explains how my or my child(ren)'s medical information will be used and disclosed, and/or I understand that I am entitled to receive a copy of this document upon my request. Furthermore, I agree to receive calls, detailed messages, or correspondence about my or my child(ren)'s appointments, lab and x-ray results, or other health care information at the address and phone numbers listed on Page 1 of this Patient Registration form.
If over the age of 14, the patient MUST sign this form.

_____ _____
Print Name (Patient or Guardian if under 14) Relationship to Patient

_____ _____
Signature (Patient or Guardian if under 14) Date

_____ _____
Witness Translator/Reader (If Applicable)