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CONCORD, NEW HAMPSHIRE 03301
Phone (603) 224-1929
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Consent for Treatment Over 18

Name of Patient: _____ DOB: _____

I authorize my provider(s) or his/her designee(s) in charge of my health care at Concord Pediatrics PA, in consultation with me, to provide services deemed necessary or advisable in the diagnosis and treatment of my child's health. I understand that I may withdraw my authorization for treatment any time in writing.

In case of emergency, I understand that the need for prompt medical attention may prevent authorization of a more detailed or specific nature before proceeding. In this circumstance, I authorize the provider(s) and their designee(s) to administer care and perform such procedures as they deem necessary.

I understand that Concord Pediatrics PA makes no guarantee to the results of care provided.

I acknowledge that Concord Pediatrics PA may at times have health care workers in training under appropriate supervision that may perform or observe some of the health care services I receive. Additionally, I understand that I may request that health care workers not employed by Concord Pediatrics PA not provide services to myself.

I acknowledge that Concord Pediatrics PA is not responsible for loss or damage of personal belonging that are brought to our office.

I understand that full policies including Privacy, Payment and Treatment are available on Concord Pediatrics PA's website ConcordPediatricsNH.com and I have reviewed them, or have requested a written copy to review and I will abide by these policies.

I acknowledge that by Federal law, when a patient turns 18 years old, parents and/or guardians will no longer be permitted access to the patient's medical records, information, providers, billing inquiries or appointment status without specific written permission by the patient.

This consent is valid until revoked in writing by me, the parent/legal guardian.

_____ _____ _____

Signature of Patient Printed Name Date

Revised 6.26.25