

CONSENT TO TREAT

Pediatric Clinic Westbank
151 Meadowcrest Street
Suite F
Gretna, La. 70056
504-392-9298

I am the parent, guardian, or personal representative of:

Name of Child

Date of Birth

I do hereby request and authorize the doctor and practice staff to perform necessary medical care and treatment for the child named above, which are deemed advisable by the doctor.

By signing this, I hereby acknowledge Pediatric Clinic Westbank has the right to use and disclose protected health information for treatment, payment and health care operations, and that I have received the **Notice of Privacy Practices** for Protected Health Information.

Signature of Parent, Guardian or Representative

Date