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CONSENT FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

Minor's Name: _____ Date of Birth: _____

I hereby authorize any physician, hospital or dentist to provide for the above named minor ordinary and necessary medical and dental examination and treatment to include those laboratory tests recommended by the Early Periodic Screening, Diagnosis and Treatment testing and any blood testing deemed necessary by documented history or symptomatology but shall exclude any test for which separate court order or informed consent is required by law. Ordinary and necessary medical and dental care shall also consist of preventive and prophylactic care, to include immunizations, tuberculin testing and well child care, but shall not include surgery, general anesthesia or other extraordinary procedures for which separate court order or informed consent is required by law. I further authorize any physician, dentist, hospital or clinic to furnish the Department of Children and Families, or its authorized agent, any verbal or written information pertaining to the present or past state of health and medical treatment given to my child. I/we also agree to be financially responsible for the care of any pre-existing medical conditions and/or any self-inflicted injuries while in the custody of the Department of Children and Families and give permission for the hospital/physician to file a direct claim to the insurance company or Medicaid on my behalf. I authorize that a photocopy of this release may be considered as valid as the original.

_____ _____ _____
Signature of Parent(s)/Guardian | Date Signed | Relationship to Minor

_____ _____ _____
Signature of Witness | Date Signed | Address

_____ _____ _____ _____
Telephone Number | Medical Insurance | Policy Number | Medicaid Number

Pre-existing medical condition:

Medication:

TO: Authorized Physician, Dentist, Hospital or Clinic

The above named minor is referred to you for medical/dental treatment. It is requested that the bill be mailed to the parents/guardian, insurance company or Medicaid as listed above. In the absence of proper consent for treatment, I am authorizing medical/dental treatment in accordance with Chapters 39 and 743, Florida Statutes.

_____ _____ _____
Signature of Authorized Agent/Title | Date Signed | Address

TO: _____

Reason for Referral:

Diagnosis/Treatment:

Physician's Signature: _____

Parent/Counselor Contact: Time and Date (copy sent to Counselor): _____

Detention/Shelter Representative's Signature: _____

Distribution of Copies: Original – Commitment package for facility
Copy – Commitment package for Central Office
Copy – Field office file copy