Practice of Chet Gentry, MD, Megan Huddleston, PA-C,
Jennifer Carter, FNP, Alison Hicks, FNP, Ree Smith, FNP-C
3300 Williams Enterprise Drive Cookeville, TN 38501 (931) 528-9222

Child's Name_____Date of Birth_____

I hereby give consent for the above named child, for whom I am the custodial parent or legal guardian, to receive medical care and treatment from Innovative Family Care in my absence. I certify that this child is at least fourteen (14) years of age. I request that the provider attempt to contact me at the phone number given below if treatment or diagnostic testing is recommended, but that contacting me is not a requirement to proceed with such treatment or testing. This serves as permission for treatment by any of the providers at Innovative Family Care. (Please understand that consent is not required in emergency situations.)

I also understand that I am still responsible for payment for services.

This consent will remain in force until withdrawn by custodial parent/guardian, until custody arrangement changes, or until patient reaches the age of maturity.

Custodial Parent/Legal Guardian _____

Signature _____ Date_____

Phone # (____)_____