Consent form authorizing evaluation of patient without parent or legal custodian.

DATE: _____

NAME OF PATIENT: _____

DATE OF BIRTH: _____

NAME OF PARENT OR LEGAL CUSTODIAN:_____

I authorize Dr. Juan Villafañe and Children's Heart Specialists, PSC, to evaluate and examine my son/daughter without my presence.

In case of emergency, I may be contacted at telephone number _____, cell phone number _____.

_____ _____
Signature Date

Patients under age 17 need to be accompanied by an adult.

Name of adult who will be accompanying the patient: _____

Signature: _____
(Parent or legal custodian)

Date: _____