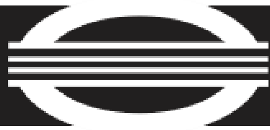

NOTICE TO REVOKE "DESIGNATION OF ANOTHER PERSON TO CONSENT TO TREAT MINOR CHILDREN" FORM

I, (parent/legal guardian) ______________________________________ am the parent of (child's name & date of birth) ____.

Please immediately revoke prior permission for (person's name)

______________________________________ to consent for medical care of my child.

X______________________________ ______________________________
(signature of parent or legal guardian) Date signed (required)

X______________________________ ______________________________
(signature of witness – 18 years of age or older) Date signed (required)

Clinic Use Only:

Revoked by (Staff Name): ______________________________________

Date: ______________________________________

In order to process your Notice of Revoke, please bring this form with you to your next visit or fax it to the appropriate clinical location. The fax number can be obtained from our Front Desk staff. If faxed, please confirm with the office that it was received.

LARGO
1225 West Bay Drive
Largo, FL 33770
(727) 581-8706

CLEARWATER
3220 McMullen Booth Rd
Clearwater, FL 33761
(727) 723-8706

ST. PETERSBURG
6133 Central Ave
St. Petersburg, FL 33710
(727) 344-3008

HYDE PARK
501 N. Howard Ave, Ste 100
Tampa, FL 33606
(813) 253-2727

WESTCHASE
11925 Sheldon Road
Tampa, FL 33626
(813) 792-0444

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