PLEASE PRINT

CONSENT FOR TREATMENT

I give my permission for Northwest Pediatrics to treat my child ______________________________

in accordance with the standard of care in the community.

Signature________________________________ Date________________

AUTHORIZATION

I authorize Northwest Pediatrics and personnel to treat my child___________________________________

in my absence when the child is brought into the office by my designee:

Name:________________________________ Relationship:_____________________________

Name:________________________________ Relationship:_____________________________

Name:________________________________ Relationship:_____________________________

Name:________________________________ Relationship:_____________________________

Name:________________________________ Relationship:_____________________________

Signature________________________________ Date_________________

PHONE AUTHORIZATION

I, _____________________________________ give Northwest Pediatrics permission to contact me and leave a message at the following phone numbers regarding my child,__________________________________'s personal health information if not available at the time of the phone call.

	It is okay to call this number with detailed information	It is only okay to contact me at this number and request a call back	It is not okay to contact me at this number
Home #________________________	☐	☐	☐
Work #_________________________	☐	☐	☐
Cell # __________________________	☐	☐	☐
E-mail#_________________________	☐	☐	☐
Other#___________________________	☐	☐	☐

Signature_______________________________ Date_________________

MAIL AUTHORIZATION

I, ________________________________ give Northwest Pediatrics permission to contact me by mail at the following address:

Address____

City_________________________ State____________________ Zip_______________

regarding my child_______________________________'s personal health information.

Signature_______________________________ Date __________________