ARBOR MEDICAL PARTNERS

North Scottsdale Pediatrics Papago Buttes Pediatrics
Scottsdale Children's Group Southwest Pediatrics
Arbor Medical Partners Pediatrics – Gilbert

MEDICAL AUTHORIZATION/ CONSENT TO TREAT

Date: _____
(valid for 1 year from date signed)

Consent from Parents or Guardians for Authorized Persons:

As the parent or guardian of _____, I am granting permission for the below listed person(s) to bring my child in for treatment and/or care.

PLEASE SELECT ONE OF THE FOLLOWING CHOICES:

_____**Initials** I am granting full consent, meaning the below listed person(s) will be allowed to agree to treatments/vaccines, and know all health history pertaining to my child.

_____**Initials** I am granting partial consent, meaning the below listed person(s) is only allowed to bring my child in, and can agree to treatments/vaccines but is not allowed to access any medical information/health history pertaining to my child.

Please list person(s) here	**Relationship**
_____	_____
_____	_____
_____	_____

Consent to Leave Voicemail

____ **Initials** I am granting consent to Arbor Medical Partners to leave phone messages regarding my child's medical health to the number(s) provided on the registration form.

_____

Parent/Guardian Signature Date

_____

Witness Signature Date