ARBOR MEDICAL PARTNERS

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

MEDICAL AUTHORIZATION/ CONSENT TO TREAT

Date: _________________
(valid for 1 calendar year)

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 will have access to all health history, but not allowed to agree to treatments without my direct consent.

Please list person(s) here (Other than parents)	Phone number	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.

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Parent/Guardian Signature   Date

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Witness Signature   Date