Park View Pediatrics
6179 S Balsam Way Suite 205 Littleton, CO 80123
Office: (303)972-2000 | Fax: (720)245-2690

Consent to Treat a Minor

Patient Name: _____ Date of Birth: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

I, the undersigned, parent(s) or legal guardian(s) of the above named patient(s), a minor, do hereby authorize the providers at Park View Pediatrics, LLC to act as agent(s) for the undersigned to consent to physical examination, medical diagnosis and treatment or other medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, the treating provider who is licensed in the state of Colorado. I further acknowledge that I am responsible for any portion of charges that are not covered by the child's insurance.

Consent to Treat an Unaccompanied Minor Child

I, the parent or legal guardian of the patient named above, do hereby authorize the providers at Park View Pediatrics to perform medical treatment as per the statements above when they present to the office unaccompanied.

This authorization is valid (please check all that apply):

- ○ For any and all medical treatment including but not limited to: preventative care / physicals and visits for illness
- ○ For vaccine administration
- ○ For this specific problem(s) or a specific date range (please specify):
  _____
  _____
  _____
  _____
- ○ Today's visit only: ____/____/____

- ➢ **This consent will be valid until revoked in writing by me from the date signed, unless otherwise specified in writing.**

Parent or legal guardian: (Print name) _____Date: ____/____/____

Parent or legal guardian signature:_____

Witness:(Print Name)_____ Signature:_____