Consent Form

Patient Name: _____ **DOB:** _____/_____/_____ **Sex: M or F**

Patient Name: _____ **DOB:** _____/_____/_____ **Sex: M or F**

Patient Name: _____ **DOB:** ____/_____/_____ **Sex: M or F**

Patient Name: _____ **DOB:** ____/_____/_____ **Sex: M or F**

I authorize the following people to represent me at Valley of the Sun Pediatrics if I am unable to personally authorize medical services for the above patients. All names below are age 18 or older. This authorization is valid until withdrawn in writing:

_____

Name (other than person completing this form or other parent/guardian) Relationship to patient Phone

_____

Name (other than person completing this form or other parent/guardian) Relationship to patient Phone

Other authorization instructions if any:

_____

Authorization for Test Results (By checking the box you are authorizing us to leave a message)

Abnormal	Normal	
☐	☐	1st Phone _____
☐	☐	2nd Phone _____
☐	☐	Work Phone_____
☐	☐	Other Contact (name, relationship, phone number)_____

Pharmacy Information

Name: _____ Address: _____

EMERGENCY CONTACT INFORMATION (Other than a parent and at a different address)

Emergency Contact:_____

Relationship to Patient: _____ 1st Phone: _____ 2nd Phone: _____

Printed Name of Parent or Guardian:_____

Signature of Parent or Guardian: _____

Relationship to Patients:_____ Date:_____