PONDEROSA PEDIATRICS

6512 S. McCarran Blvd, Suite D
Reno, NV 89509
Phone: 775-900-9987
Fax: 775-900-9954

Authorization to Treat a Minor – Optional

Patient Name: _____ **D.O.B.:** _____

I authorize the person(s) listed below to accompany my child and authorize treatment for my child in accordance with the office policy of Ponderosa Pediatrics. This includes bringing the child to the office, providing an accurate medical history, disclosing protected health information, consenting to vaccinations and any procedures, and witnessing any physical examination by the provider. This adult has the responsibility to relay diagnoses and treatment plans to the parent or legal guardian. This adult also can make, change, or cancel appointments, manage health forms, and pick up prescriptions for the child. I agree to continue to comply with the financial policy.

Name: _____ D.O.B.: _____
Phone: _____ Relationship to patient: _____

Name: _____ D.O.B.: _____
Phone: _____ Relationship to patient: _____

THIS CONSENT IS VALID FOR 2 YEARS FROM DATE SIGNED AND IS REVOCABLE BY EITHER PARENT AT ANY TIME.

Parent Name: _____ Phone Number: _____

Signature: _____ Date: _____