



6512 S. McCarran Blvd, Suite D
Reno, NV 89509
Phone: 775-900-9987
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Authorization to Treat a Minor

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.

_____ No other adults are authorized to bring my child to appointments.

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

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

THIS CONSENT IS MAY BE REVOKED AT ANY TIME BY EITHER PARENT OR LEGAL GUARDIAN.

Parent Name: _____ Phone Number: _____

Signature: _____ Date: _____