

PLEASE PRINT

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**CONSENT FOR TREATMENT**

I give my permission for Northwest Pediatrics to treat my child \_\_\_\_\_  
in accordance with the standard of care in the community.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**AUTHORIZATION**

I authorize Northwest Pediatrics and personnel to treat my child \_\_\_\_\_  
in my absence when the child is brought into the office by my designee:

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**PHONE AUTHORIZATION**

I, \_\_\_\_\_ give Northwest Pediatrics permission to contact me and leave  
a message at the following phone numbers regarding my child, \_\_\_\_\_'s  
personal health information if not available at the time of the phone call.

	It is okay to call this number with detailed information	It is only okay to contact me at this number and request a call back	It is not okay to contact me at this number
Home # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cell # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-mail# _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other# _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**MAIL AUTHORIZATION**

I, \_\_\_\_\_ give Northwest Pediatrics permission to contact me by mail at the  
following address:

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

regarding my child \_\_\_\_\_'s personal health information.

Signature \_\_\_\_\_ Date \_\_\_\_\_