North Scottsdale Pediatric Associates, PC
Fax: 480-860-8498 (Main Office)

CONSENT TO TREAT

Date: _____ Expires on: _____
(valid for 6 months)

Consent from Parents or Guardians for Authorized Persons :

As the parent or guardian of _____, I am granting permission for the below listed person(s) to bring my child in for treatment and/or care.

PLEASE SELECT ONE OF THE FOLLOWING CHOICES:

I am granting full permissions, meaning the below listed person(s) will be allowed to agree to treatments/vaccines, and know all health history pertaining to my child. _____ **Initials.**

I am granting permissions, meaning the below listed person(s) is only allowed to bring my child in, and will have access to all health history, but not allowed to agree to treatments without my direct consent. _____ **Initials.**

I am granting limited permissions, meaning the below listed person(s) is allowed to bring my child in to the office, but is not allowed access to any medical information or treatment of my child. I will be informed of the visit results, and I will be notified prior to any treatment for my child. ____**Initials.**

Please list person(s) here	**Relationship**
_____	_____
_____	_____
_____	_____

Consent to leave voicemail

I am granting permission to North Scottsdale Pediatrics to leave phone messages regarding my child's medical health to the number(s) provided on the registration form. _____Initials.

_____
Parent/Guardian Signature Date

_____
Witness Signature Date