Consent and Authorization for Treatment of a Minor

3340 Providence Dr., Ste. 452
Anchorage, AK 99508
Phone: 907-562-2120 Fax: 907-562-6527

Today's Date_____________________

Patient's Name____ Date of Birth_______________

This is my authorization and consent for the below named person or persons to bring my child to LaTouche Pediatrics, LLC., to be treated by any of our medical providers. Treatment may include any necessary or routine medical treatment including examination, injections, immunizations and/or diagnostic procedures including ordering X-ray or laboratory analysis. I understand that in unusual circumstances, efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

Please Initial all that apply (signature at bottom of page is also required)

_____ Bring patient for treatment

  _____ Sick Visits

  _____ Well Child Checks (Physicals)

_____ Request/Receive Medical Records

_____ Pick up prescriptions *(excluding controlled substances)*

______ Pick up controlled substance prescriptions

_____ Speak to Triage Nurse

I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered and acknowledge that no guarantees have been made as to the effect of such treatment rendered.

Person(s) authorized for the activities initialed above:

Name	Relationship to Patient:
____	__________________________
____	__________________________
____	__________________________

This authorization will remain in effect for one year unless so designated in writing that such consent is cancelled. Expiration Date *(less than one year)*: _________________

____ __________________________

Print your Name (Parent or Guardian) Relationship to Patient

____ __________________________

Signature of Parent or Guardian Date