1330 Oakridge Drive, #100
Fort Collins, CO 80525
p 970.484.4871
f 970.482.4927
pediatricassociatesnc.com

PARENT AUTHORIZATION FORM

Date: ____________________

Patient Name: ___________________________________ DOB: ______________

I, ____
(printed name and relationship to patient)

hereby grant permission for ____
(printed name and relationship to patient)

to seek medical treatment for my above-named child, at Pediatric Associates of Northern Colorado. This authorization includes, but is not limited to, treatments and procedures prescribed by the health care provider, and prescription medications. I understand I will be responsible for all costs associated with these services.

This authorization is good for the following time period:

Beginning Date: ____

Ending Date: ____

Parent Signature: ____

Revised: 06/09/2012