ARBOR MEDICAL
PARTNERS

MEDICAL AUTHORIZATION/ CONSENT TO TREAT

Date: _____
(Valid for 1 calendar year)

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:

_____**Initials** I am granting full **consent**, 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 partial consent, 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.

Please list person(s) here	**Relationship to the patient**
_____	_____
_____	_____
_____	_____

Consent to Leave Voicemail

___ **Initials** I am granting consent to Arbor Medical Partners to leave phone messages regarding my child's medical health to the number(s) provided on the registration form.

_____

Parent/Guardian Signature Date

_____

Witness Signature Date