PERMISSION TO TREAT CHILDREN – *This is for sick visits only at LYNK Pediatrics* (not well visits)

I (We), _____, am (are) the parent(s) or legal guardian of:

NAME	BIRTH DATE	ALLERGIES	LAST TETANUS	MEDICATIONS, CHRONIC ILLESSES

grant to _____
the authority to consent to outpatient or inpatient medical/surgical treatment of any above named minor(s). Should his/her condition require treatment, the above named person having physical custody or responsibility for the care of the minor(s) in need may bring this consent to the physician or hospital. This permission may include transportation and/or admission to an appropriate health care facility.

I (We) understand medical or surgical treatment can include diagnostic laboratory or radiologic testing, intravenous feedings, injections, blood transfusions, medical care, or surgery considered necessary in the situation. I (We) set no limitations on treatment of the above named minor(s) other than:
_____

I (We) understand that reasonable attempts will be made to contact me (us), as well as the personal physician listed below, time and conditions permitting. This authorization is effective from the date of signature until the following date: _____ (not to exceed nine (9) months from date of signature).

_____ _____
Signature of parent/legal guardian **Signature of parent/legal guardian**

_____ _____ _____ _____
Date **Relationship to Child** **Date** **Relationship to Child**

Additional Information

Primary Care Physician : LANCE LAZATIN, MD Child's Address _____

City: WHEAT RIDGE Phone: 303-423-8017 City/State/Zip _____ Phone _____

Insured Work Place _____

Address _____ Phone _____ Address _____ Phone _____

Other Contact _____ Address/Phone _____

Health Insurance Company _____

Name of Policy Holder _____ Policy & Group # _____