NOE VALLEY
PEDIATRICS

GENERAL CONSENT TO TREAT

PATIENT NAME: _____

I am the parent/guardian of the patient listed above and have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to such medical care, treatment and diagnostic test that the doctors of Noe Valley Pediatrics and his/her designated associates or assistants believe are necessary for this child. I understand that, by signing this form, I am giving permission to the doctors, nurses and other health providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

SIGNATURE:

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative | Date

_____ _____

Printed Name of Authorized Representative | Relationship to patient

DELEGATION OF CONSENT

I hereby authorize (when I am unavailable to provide consent) the following individual(s),

_____

whose relationship to the patient is _____,

to consent to any and all medical care and attention for the patient which is deemed necessary and appropriate by a healthcare provider licensed in the state of California. This consent includes, but is not limited to, medical and surgical intervention, and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

SIGNATURE:

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative | Date

_____ _____

Printed Name of Authorized Representative | Relationship to patient