ARIZONA PEDIATRIC CLINICS

809 E. Washington St., Suite 106
Phoenix, AZ 85034
(602) 340-9455 phone
(602) 523 -5359 fax

1847 E. Southern Ave., Suites 3&4
Tempe, AZ 85282
(480) 897-1122 phone
(480) 237-1213 fax

EXPRESSED WRITEN CONSENT

Date: _____

I, _____ (parent/guardian) authorize the following person(s):

_____

_____

_____

to seek and authorize medical treatment/care for :

_____ (Patient's Name)

_____/_____/_____ (Patient's D.O.B.)

(*If you have additional children that need to be covered by this authorization, please use a separate sheet for each child.)*

_____ _____

APC Employee Date Parent/Guardian Signature Date

Fecha: _____

Fecha de Vencimiento: _____

(Si no indica una fecha, este autorización se vencerá en dolce meses.)

Yo, _____, (padres o guardian) autorizo