PTHA CONSENT AGREEMENT CHILDREN'S TREATMENT

I am the mother / father / legal guardian of the following named child.

I hereby give my consent for my child listed below.

Name of Patient – First/MI/Last (Please print)		
Street Address		
City	State	Zip
Date of Birth	Phone Number	

I hereby authorize the below named individual(s) to care for my child, to have the authority to provide all necessary treatment (medical, dental, etc.). I verify and acknowledge that the below named individual(s) is 18 years old or older. The person bringing my child has been instructed to bring photo ID. I can revoke this consent and terminate at any time.

Unless otherwise revoked, this authorization will expire on the following date: _____
If I fail to specify an expiration date this authorization will expire in 90 days from the date signed.

_____ _____ _____

Signature of Parent/Guardian Date/Time Relationship

Name of Authorized Individual, please print full legal name and date of birth

1) _____

2) _____

3) _____

4) _____