MOUNTAINLAND
PEDIATRICS

AUTHORIZATION FOR CHILD'S TREATMENT

Patient Name _____ , DOB _____

I hereby give Mountainland Pediatrics specific authorization to treat me, including authorization to administer immunizations, when I may be brought to the practice by any of the following caregivers.

I further authorize the practice to triage or discuss with the designated caregivers, either in person or by phone, my child's symptoms and/or medical condition in order to assist and advise the caregiver concerning the immediate treatment options for me. This includes releasing relevant medical information to the caregiver, on a need to know basis.

Please indicate name and relationship to you, the patient:

Name and Phone Number _____ Relationship _____

Name and Phone Number _____ Relationship _____

Name and Phone Number _____ Relationship _____

Name and Phone Number _____ Relationship _____

_____ _____

Signature of Patient Date