Spokane Pediatrics
315 W. 9th Ave, Suite 200
Spokane, WA 99204

Authorization for Non-Parent Consent for Treatment of Minor Child

Please fill out this form if your child will be coming for a visit, treatment, or procedure, accompanied by someone other than a parent or legal guardian. This agreement will stay in effect for one year from the date of signature below unless revoked in writing by a parent or legal guardian.

_____ _____
Printed Name of Minor Child Date of Birth

1._____
Printed Name of Person Approved to Seek Medical Care for the Above-Named Minor Child

2._____
Printed Name of Person Approved to Seek Medical Care for the Above-Named Minor Child

I approve the above-named persons to seek health care for my minor child listed above. I know that I am financially responsible for all health care fees incurred by my child during these visits.

_____ _____
Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian

☐ Primary Custody ☐ Shared Custody ☐ Sole Custody

_____ _____
Date of Signature Phone Number of Parent/Legal Guardian