623.565.5060 ● Phone
623.565.5061 ● Fax
Contact@NFMAZ.com

NORTERRA
FAMILY MEDICINE

2060 W. Whispering Wind Drive, #173
Phoenix, AZ 85085
NorterraFamilyMedicine.com

AUTHORIZATION FOR CONSENT TO TREAT A MINOR

I, _____, hereby authorize _____,
(Parent/Legal Guardian) *(Name)*

_____ to obtain medical treatment and/or immunization(s) for my child:
(Relationship to Patient)

Patient Name: _____ Date of Birth: _____

This authorization gives consent to Medical Treatment being provided by Norterra Family Medicine and is limited to the following time period:

Date Range: _____

If no time period is designated, this authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____