CHILDREN'S MEDICAL GROUP, LTD
6780 W. THUNDERBIRD RD., STE A101
PEORIA, ARIZONA 85381
(602) 843-1991 FAX (602) 843-3224

TREATMENT AUTHORIZATION

I, _____ hereby authorize _____
Please print name of parent / legal guardian Print name of person you authorize

_____ to bring _____, _____
Please print - relationship to child Print child's name Date of Birth

for medical care provided by Children's Medical Group, Ltd.

This consent includes the authorization for treatment, medication, injections, immunizations and laboratory tests as necessary. I understand medical diagnosis will be discussed.

_____ _____ _____
Signature of Parent / Guardian Social Security Number Date

THIS AUTHORIZATION CAN BE REVOKED (IN WRITING) AT ANY TIME. PERIODIC UPDATES MAY BE REQUIRED.

Update: _____ Parent/Guardian Initials: _____ CMG INT'S: _____

Update: _____ Parent/Guardian Initials: _____ CMG INT'S: _____

Parent / Guardian Signed in Office ( )

Signature verified with: Driver Lic.( ): State I.D. ( ): Green Card ( ): Employee I.D. ( )

Other:_____ CMG Rep. Int's: _____

CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE. IN ADDITION, MY SIGNATURE AUTHORIZES A PHOTOGRAPH TO BE TAKEN OF MY CHILD.

_____ _____
Please **Print** name of child Date of birth