Parental Consent

Southern Oregon Pediatrics
750 Murphy Road
Medford, OR 97504
541-789-4096

I, _____ Authorize

_____ Relation to patient _____

_____ Relation to patient _____

To seek medical care for the following patient(s):

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

Duration of time:

___ Date of service only _____

___ 1 Week

___ 1 Month

___ Range of Dates _____ to _____

___ No expiration date

Guardian/Parent_____ Date: _____

Signature if you want revoked: _____ Date: _____