ALASKA UROLOGY

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Consent and Authorization for Treatment of a Minor

Today's Date: _____

Patient's Name: _____Date of Birth: _____

This is my authorization and consent for the below named person or persons to bring my child to Alaska Urology to be treated by any of our medical providers. Treatment may include any necessary or routine medical treatment including examination, injections, specimen collection and/or diagnostic procedures including ordering X-rays or laboratory analysis. I understand that in unusual circumstances, efforts will be made to contact me prior to the rendering or treatment, but that medical treatment will not be withheld if I cannot be reached.

Please initial all that apply (signature at bottom of page is also required)

_____Bring patient for treatment

_____Office Visits

_____Procedures

_____Schedule Appointments

_____Request/Receive Medical Records

_____Pick up Prescriptions (*excluding controlled substances*)

_____Pick up controlled substance prescriptions

I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered and acknowledge that no guarantees have been made as to the effect of such treatment rendered.

Person(s) authorized for the activities initialed above:

Name: _____ Relationship to Patient: _____

_____ _____

_____ _____

This authorization will remain in effect unless so designated in writing that such consent is cancelled.

_____ _____

Print your Name (Parent or Guardian) Relationship to Patient

_____ _____

Signature of Parent or Guardian Date