



CONSENT AND AUTHORIZATION

CONSENT FOR TREATMENT OF A MINOR:

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

This authorization will remain in effect for one year unless so designated in writing that such consent for treatment of minor is cancelled.

Date: _____

Patient's Name: _____ DOB: _____

Print your Name (Parent or Guardian): _____

Signature of Parent or Guardian: _____

Relationship to Patient: _____

Person(s) authorized to bring patient for treatment:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Expiration Date: _____