Grants Pass Clinic, LLP
495 SW Ramsey Avenue
Grants Pass, OR 97527
541-472-5560

PARENTAL CONSENT FORM

I give permission for_____
Representative's Name

OR_____ OR _____
Representative's Name *Representative's Name*

to take my child:_____ _____
Child's Name *Child's Date of Birth*

to Dr._____or the covering physician at Grants Pass Clinic, LLP.

I also give permission for the physician to examine and treat my child. I designate that the above named representative(s) may receive protected health information regarding my child and their visit to the doctor.

My child has the following drug allergies:_____

_____

_____ _____
Signature of Parent or Guardian *Date*

Right to Revoke: If you decide you do not want the person(s) named above to continue to act on behalf of your child you have the right to revoke this permission. Any revocation can only apply on or after the date that we receive your Revocation.

REVOCATION:

I no longer want the person(s) named above to act on behalf of my child. All permissions listed above are no longer applicable.

Signature_____Date_____

Rev 01/12