ARIZONA CENTER FOR
Hand to Shoulder Surgery

Hand to Shoulder Surgery & Reconstructive Microsurgery • www.achssurgeons.com

CONSENT FOR MINOR CHILDREN

Patient's Name: _____

Patient's Date of Birth: _____ **Patient Acct #:** _____

Parent/Legal Guardian: _____

I give permission for the following individual(s) to bring my child listed above in for medical evaluation, testing and treatment. In addition, I give permission for the individual(s) list below to pick up any prescription (except for State Controlled prescriptions), patient information, X-ray or lab requisition and test results.

If at any time you the parent/legal guardian wish to change the individual(s) listed below, you **must** notify us in writing (i.e., fill out a new form).

This consent is valid for one (1) year from the date signed.

Name of Parent/Guardian here today with minor:_____

Relationship: _____

Address:_____

Phone: _____

Name: _____ Relationship: _____

Address: _____

Phone: _____

Name: _____ Relationship: _____

Address: _____

Phone: _____

Parent/Legal Guardian Signature _____

Date: _____

370 East Virginia Avenue, #100, Phoenix, Arizona 85004 ● P.O. Box 7587, Phoenix, AZ 85011-7587
Phone (602) 258-4788 ● Fax (602) 258-5131