goldstar pediatrics

15290 Summit Avenue, Suite B
Fontana, CA 92336
Tel: (909) 225-1900 Fax: (909) 663-9072

Consent to Treat

Patient's Name _____ Date of Birth __/__/_____

Please sign **one** of the options below.

OPTION 1

I authorize Dr. Tackie or any Goldstar Pediatrics' provider to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, I authorize that my child may be treated in my absence. I understand that I am responsible for settling any costs arising from this care provided in my absence.

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship

For patients 16 years and older ONLY:
The patient listed above may present and be treated unaccompanied by an adult. Yes/No

Signature: _____ Date __/__/_____

Relationship: _____

OPTION 2

I authorize Dr. Tackie or any Goldstar Pediatrics' provider to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, I do not authorize that my child be treated in my absence. I understand that by signing below, my child will not be treated unless a parent or legal guardian is present.

Signature: _____ Date __/__/_____

Relationship: _____

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