Consent to Treat

With my signature:

I hereby authorize consent for medical treatment and care for the patient listed below.

In the rare event that I cannot be reached, I hereby authorize Woodinville Pediatrics to institute any necessary care for this patient in my absence. This includes hospitalization in the case of an emergency.

This form must be signed by a parent or guardian if the patient is under the age of 18.

☐ **I accept**

☐ **I decline** and understand that the patient will not be able to receive medical care at Woodinville Pediatrics.

Patient Name _____ Patient Date of Birth _____

Signature of patient or parent/guardian if patient is under 18 _____

Printed Name of Person Signing _____ Date _____ Relationship to Patient _____

This form will be retained in the patient's medical record.

Woodinville Pediatrics uses a shared Epic electronic medical record system hosted by Seattle Children's Hospital, allowing authorized care teams to access patient information.