



Pediatric Associates  
of the Northwest, P.C.

Authorization to treat in the absence of parent or guardian

I authorize the following person(s)

\_\_\_\_\_, my \_\_\_\_\_,  
\_\_\_\_\_, my \_\_\_\_\_,  
\_\_\_\_\_, my \_\_\_\_\_,

to be present at any exam and consent to treatment by any provider at PANW, P.C.

This authorization is for my child/children,

First Name	Last Name	Date of Birth

Parent/Guardian Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

Not applicable at this time \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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[www.PediatricAssociatesNW.com](http://www.PediatricAssociatesNW.com)

Lake Oswego Office:  
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503-636-4508 telephone 503-635-3729 fax  
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