Children's Eye Care
OF NORTHERN COLORADO

at UC Health Harmony Campus
2121 E. Harmony Rd., Suite 350A
Fort Collins, CO 80528
Phone # (970) 214-8175
Fax # (970) 788-7376

PARENT AUTHORIZATION FORM

Date: _____/_____/_____

Patient Name: _____

Patient Date of Birth: _____/_____/_____

I, _____ (printed name and relationship to patient) hereby grant permission for _____ (printed name and relationship to patient) to seek medical treatment for my above-named child, at Pediatric Associates of Northern Colorado. This authorization includes, but is not limited to, treatments and procedures prescribed by the health care provider, and prescription medications. I understand I will be responsible for all costs associated with these services.

This authorization is good for the following time period:

Beginning Date: _____/_____/_____ Ending Date: _____/_____/_____

Parent Signature: _____