WILLIS-KNIGHTON PHYSICIAN NETWORK

pediatric healthcare associates
of Shreveport

## *AUTHORIZATION FOR TREATMENT*

LYNNE F. HOLLADAY, MD
ASHLEY M. WHITE, MD, FAAP

1717 East Bert Kouns
Industrial Loop
Shreveport, LA 71105
Phone: (318) 212-2920
Fax: (318) 212- 2910
wkpeds.com

Patient's Name: _____

DOB: _____

In the event of an emergency and I, the parent, am not present or cannot be located immediately, I authorize ***Pediatric Healthcare Associates*** to perform whatever emergency (Life Saving) treatment or procedures that he/she feels necessary.

Additionally, in my absence, I specifically empower the following individuals to give consent to medical treatment for my child, including, but not limited to immunizations.

Please list all people authorized to give consent, be notified in case of emergency in order of priority, or able to bring the child in **(other than the parents of the child)**:

1. Name: _____

   Phone #: _____

2. Name: _____

   Phone #: _____

3. Name: _____

   Phone #: _____

This authorization will remain in effect unless changed by me while my child is a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Willis-Knighton Systems Privacy Officer.

I agree that should I revoke this authorization; I will give written notice.

Parent / Guardian Signature: _____ Date/Time: _____

Witness Signature: _____ Date/Time: _____