Seattle Sports &
Regenerative Medicine

PARENTAL CONSENT FORM

I do hereby authorize the Seattle Sports & Regenerative Medicine, 1000 Dexter Ave N., Suite #320, Seattle, WA 98109, to render medical and/or surgical care to my dependent child

_____.
(Patient Name)

This authorization includes routine as well as emergency treatment, and remains in effect until revoked by me in writing or the child reaches legal age. If a fee is charged for services, I assume full responsibility for payment.

I authorize my insurance benefits to be paid directly to the provider, and authorize the provider or insurance company to release any information required for this claim.

_____ _____
(Signature of parent/guardian) (Relationship to patient)

_____ _____
(Typed or printed name) (Date)

_____ _____
(Street address) (Home phone number)

_____ _____
(City, state, zip) (Daytime phone number)

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