Medical Genetics of Nevada LLC

Susanna Sorrentino, MD, FACMGG, FAAP
3006 South Maryland Parkway, Suite 515
Las Vegas, Nevada 89109
Phone: 702-732-6800
Fax: 702-932-9611

Routine or Emergency Consent for Treatment

Name of Patient/Child_____

Date of Birth_____

Allergies_____

In the event of accident, illness or emergency, I hereby authorize

_____

(persons other than biological parents/legal guardians, for example grandparents, siblings, friend, babysitter/nanny etc.)

To give consent and/or secure medical aid/or treatment from Medical Genetics of Nevada or the nearest hospital/medical office.

I agree to be directly responsible for all costs and expenses connected the examination, diagnosis and medical treatment for myself/my child/dependent.

_____

Print and Sign Parent/Guardian

_____

Date

This form is valid for one year from date of signature