



Chico Clinic

845 W. East Avenue
Chico, CA 95926
(530) 896-9400
Fax: (530) 896-9407

Dental and Maternal Health Center

500 Cohasset Rd. Ste 15
Chico, CA 95926
(530) 433-2500
Fax: (530) 433-2510

Children's Health Center

277 Cohasset Road
Chico, CA 95926
(530) 781-1440
Fax: (530) 342-1663

Red Bluff Clinic

2500 N. Main Street
Red Bluff, CA 96080
(530) 529-2567
Fax: (530) 529-2552

Willows Clinic

207 N. Butte Street
Willows, CA 95988
(530) 934-4641
Fax: (530) 934-4081

Woodland Clinic

175 West Court Street
Woodland, CA 95695
(530) 661-4400
Fax: (530) 661-4416

Mobile Dental Clinic
530-520-6913

www.nvih.org

Northern Valley Indian Health, Inc.

AUTHORIZATION TO SEEK MEDICAL CARE

Date: _____

As the parent or legal guardian of _____, I authorize
_____ to seek healthcare attention for my child from
_____ to _____. I also consent to any medical treatment or procedures,
(start date) (end date)

to be performed for my child by a licensed medical provider, that are necessary or advisable in the interest of my child's wellbeing.

This form is valid for a maximum of one year. It is the parent or legal guardian's responsibility to notify Northern Valley Indian Health of any changes that might apply.

Under the circumstances set forth above, I elect not to be informed in advance of the nature character of the proposed treatments, its results, possible alternatives, and the risks, complications, and anticipated benefits involved in the proposed treatments, and the alternative forms of treatment, including non-treatment.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

FOR NVIH USE ONLY:

HRN

Patient Name