



Medical Genetics of Nevada LLC

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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 to the examination, diagnosis and medical treatment for myself/my child/dependent.

Sign Parent/Guardian: _____

Print Name: _____

Date: _____

This form is valid for one year from date of signature