

CONSENT FOR TREATMENT

I, _____, the parent and/or legal guardian
(please print)
of the following children,

1. _____ 2. _____
3. _____ 4. _____

I hereby authorize (name of person or persons allowed to bring the child or children to the office)

1. _____ 2. _____
3. _____ 4. _____

To accompany my above named child/children to office visits with any physicians in Pediatric & Adult Medicine, Inc. and to consent to the examination and/or treatment of my child during the office visit.

This authorization:

is effective only on _____, 20____

is effective from _____, 20____ to _____, 20____

is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by me in writing.

Signature of Parent or Guardian

Date