CONSENT TO TREAT

(Authorized persons to consent for medical treatment- i.e., grandparents, aunts, etc.)

Patient _____ **DOB** _____

I, _____ as the parent or legal guardian of the patient named above give my permission for:

1. _____ _____

(Name) (Relationship to patient)

2. _____ _____

(Name) (Relationship to patient)

to bring my child to **PRIMARY CARE PEDIATRICS** for:

□ any medical treatment.

□ treatment limited to _____ .

In doing so, I understand that I will be financially responsible for the cost of any services that are rendered. I also understand that the person bringing my child will receive information on the child named above and should relay this information to me.

I authorize messages to be left regarding appointments, billing information, referrals, prescriptions, or other reasons at whatever contact number I provided.

This agreement is effective as long as PRIMARY CARE PEDIATRICS provides services to the patient(s) listed on this form.

This permission should also apply to the following children (if applicable):

_____

_____

_____

_____

_____ _____

Signature of parent or legal guardian Date