DATE: ___________________________

PATIENT NAME: ___________________________________DOB: __/_____/______

Consent to treat

I give All Ages Pediatrics permission to release information, to see, evaluate and treat the above named patient in my absence. (This includes laboratory evaluation, vaccinations, imaging or any other therapy the physician feels is medically necessary.)

PERMISSION TO ACCOMPANY PATIENT TO APPOINTMENTS

(Name of people to accompany patient)____
(relationship to patient, i.e. sister, aunt) ______________________________)has my permission to accompany the above patient to their appointments.

*Guardian Signature*____
Relationship____________________________________

This form will auto renew yearly unless we are notified by parent within 15 days of anniversary date.