AUTHORIZATION FOR TREATMENT CONSENT FORM

Date: _____ / _____ / _____

I, _____ give permission to
(parent or legal guardian's name)

_____to seek medical treatment and
(person who will be bring the child to the appointment)

make any medical decisions as necessary for my child.

Patient Name: _____Date of Birth: ____ / ____ / _____

Parent / Legal Guardian's SIGNATURE: _____