Pediatric & Adult Medicine, Inc.
A Member of CHOC Children's Network

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Consent for Treatment

Patient Name: _____

Date of Birth: _____

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

Name:	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

To accompany my above-named child 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 Printed Name of Parent or Guardian

_____
Date