

AUTHORIZATION FOR MEDICAL TREATMENT

I authorize, _____ to be evaluated by the attending physician
(Myself/Name of patient)

on staff at **Gabriel Pediatrics, PC**. I understand that I will be informed of any medical treatment or procedures to properly treat myself, or the patient. Authorization is hereby granted for such treatment and procedures. My signature below will act as authorization for today's and all future medical treatment, unless I rescind such authorization in writing.

Patient or Parent/Guardian Signature

Date

Who if anyone other than the responsible party has permission to be involved in your child's medical treatment including bringing them in for visits?

Name Relationship

Name Relationship

Name Relationship

Name Relationship

Patient or Parent/Guardian Signature

Date