AUTHORIZATION FOR MEDICAL TREATMENT

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

on staff at **GPM 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 (i.e. – spouse, aunt, babysitters, grandparents, etc.)?

****Please note we will not be able to see your child in absence of your presence unless one of the parties listed below accompanies your child.****

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

_____ _____
Patient or Parent/Guardian Signature Date