CHILDREN'S MEDICAL GROUP, P.A.

AUTHORIZATION TO SEEK TREATMENT FORM

Patient Name				Date of Birth			
I give the following persons/entities listed treatment for my minor child in my absence.	below	permission	to	seek	medical	attention/	
							
Patient/Parent/Legal Guardian Name (Please print)		Relation	nship	to Pa	tient		
x							
Signature of Patient/Parent/Legal Guardian		Date					