



AUTHORIZATION FOR TREATMENT

Date: _____

Patient Name: _____

Date of Birth: _____

Patient Name: _____

Date of Birth: _____

Patient Name: _____

Date of Birth: _____

Patient Name: _____

Date of Birth: _____

Patient Name: _____

Date of Birth: _____

Patient Name: _____

Date of Birth: _____

In the event that I am unable to bring my child(ren) to the office, I consent for the following persons to authorize medical care that is recommended by any of the ESD Pediatric Group physicians.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Parent/Guardian Signature: _____