PERMISSION TO TREAT

Pediatric Associates of Austin, P.A. has my permission to diagnose and to treat my child

_____(DOB)_____in my absence when
Patient Name

he/she is accompanied by the following person(s):

Name: Relationship: Telephone Number:

_____

_____

_____

_____

_____

Date: _____Guardian Signature: _____

This document will be considered for 1 year from signed date unless otherwise specified.

8/14/03