Permission to Treat Patient

I (we)_________________________________authorize Northwest Pediatrics of
Print Name of Legal Guardian(s)

Columbus, Ohio and its personnel to deliver medical services to my child,_________________________________.
Print Child's Name and Date of Birth.

I (we) authorize the following people to bring my child in for treatment:

Name:_________________________________ Relationship: ____________________

Name:_________________________________ Relationship: ____________________

Name:_________________________________ Relationship: ____________________

Name:_________________________________ Relationship: ____________________

Name:_________________________________ Relationship: ____________________

_________________________________ ____________________
Signature of Legal Guardian Date

____
Relationship to Patient