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