WINSTON-SALEM Pediatrics

AUTHORIZATION FOR TREATMENT

WINSTON-SALEM Pediatrics

PATIENT FULL NAME _____

PATIENT DATE OF BIRTH _____ /_____ /_____

THE FOLLOWING INDIVIDUALS HAVE MY PERMISSION TO BRING MY CHILD TO PARTICIPATE IN TREATMENT AND FULL CONSULTATION (INCLUDING PHONE CALLS) WITH THE DOCTOR OR ANOTHER WINSTON-SALEM PEDIATRICS EMPLOYEE.

NAME _____ **RELATIONSHIP** _____

NAME _____ **RELATIONSHIP** _____

NAME _____ **RELATIONSHIP** _____

NAME _____ **RELATIONSHIP** _____

NAME _____ **RELATIONSHIP** _____

PARENT/LEGAL GUARDIAN SIGNATURE _____ **Date** _____ /_____ /_____