

## Permission to Treat Form

I, \_\_\_\_\_ give my permission for the  
*(print name of parent, guardian, or custodian)*

following person(s):

\_\_\_\_\_  
*Name Relationship to Child/Patient (caregiver, grandparent, friend, etc.)*

\_\_\_\_\_  
*Name Relationship to Child/Patient (caregiver, grandparent, friend, etc.)*

\_\_\_\_\_  
*Name Relationship to Child/Patient (caregiver, grandparent, friend, etc.)*

to seek medical treatment for the child/children/patient named below:

\_\_\_\_\_  
*Child/Patient Name*

\_\_\_\_\_  
*Date of Birth*

I understand that this consent is **valid for one year from the date below**, and may be revoked at any time by giving written notice.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Expiration Date*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Expiration Date*

*Created: 02/23/2017*

*Approved by Quality Risk & Safety: 03/15/2017*

*Approved by Operational & Clinical Performance: 04/12/2017*

*Approved by Quality & Safety: 04/18/2017*