TWIN PEDIATRICS, P.C.

TREATMENT AUTHORIZATION

I, _____ hereby authorize _____,
Please print (parent/guardian) Please print name

_____, to bring _____, _____/_____/_____
Relationship to child please print child's name date of birth

For medical care provided by Twin Pediatrics, P.C.

This consent includes the authorization for treatment, medication, injections, Immunizations and laboratory tests as necessary.

_____ _____-_____-_____ _____/_____/_____
Signature of Parent/Guardian Social Security Number Today's Date

_____ _____ _____/_____/_____
Signature of Twin Pediatrics Staffer Title Today's Date

THIS AUTHORIZATION CAN BE REVOKED (IN WRITING) AT ANY TIME.

PERIODIC UPDATES WILL BE REQUIRED.

Update: _____ Initials: _____

Update: _____ Initials: _____

Signature & ID Verified: [ ] Yes [ ] No Twin Pediatrics Rep. Initials: _____