



*Pediatric  
Professional  
Association*

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Name of Child \_\_\_\_\_  
DOB of Child \_\_\_\_\_  
Name of Parent or Guardian \_\_\_\_\_  
Chart Number \_\_\_\_\_

## Consent to Treat Without Parent

I authorize the persons listed below to bring my child in to Pediatric Professional Association to receive medical attention without my appearance. I understand that medical information about my child may be provided to my caregiver. I may revoke this consent at any time with written notice. I understand this authorization will expire one year from date signed.

Name of Caregiver	Relationship to child	Date of Authorization
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date