PEDIATRIC MEDICINE, PA

Michael A. Ozer, M.D.
Rebecca A. Rocha-Davis, M.D.
Karen L. Gibbons, M.D.
David M. Ross, Jr., M.D.
Patricia Villarreal, RN, MS, CPNP

CONSENT TO TREATMENT

I, _____AM THE: ____ PARENT
____ LEGAL GAURDIAN
____ OTHER:_____
(PLEASE SPECIFY)
OF _____, I AUTHORIZE THE FOLLOWING:

	NAME:	RELATIONSHIP
PERSON(S)	_____	_____
PERSON(S)	_____	_____

TO MAKE MEDICAL, AND SURGICAL DECISIONS (WHEN NECESSARY)

I HEREBY GIVE CONSENT TO: ___ DR. MICHAEL OZER

___ DR. REBECCA ROCHA-DAVIS

___ DR. KAREN GIBBONS

___ DR. DAVID ROSS

___ PATRICIA VILLARREAL, CPNP

AND THEIR ASSOCIATES TO EXAMINE AND ADMINISTER ANY NECESSARY MEDICAL/SURGICAL CARE (WHEN NECESSARY) FOR

_____.
(PATIENT'S NAME)

_____ _____
SIGNATURE DATE

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