



Consent to Treat

*For non-custodial parents/guardians

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

I, _____, as a parent or legal guardian of the child(ren) listed
above authorize _____ to bring my child(ren) to Forest Hills
Pediatrics for the following types of visits:

___ Evaluation and Treatment

___ Immunizations

___ Well Child Visits

___ Lab Tests

You may reach me at the following number _____.

Preferred Pharmacy: _____

Signature: _____ Date: _____

This authorization is valid **FOR UP TO ONE YEAR** unless revoked sooner by me.