Consent to Treat

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 or until revoked by me.