Eduardo Diaz, MD, PA
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Permission to Treat

I (We) _____ authorize **Dr. Diaz Pediatrics** and its personnel to
(Print name(s) of legal guardian(s)
deliver medical services to my child(ren):

_____
Print child's name and DOB

_____
Print Child's name and DOB

_____
Print Child's name and DOB

_____
Print Child's name and DOB

_____
Print child's name and DOB

I (We) authorize the following people to bring my child in for treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature of legal Guardian Date

Relationship to patient:_____