

Authorization to Treat Minor Children

I hereby consent to and authorize the physicians at Columbia Pediatrics Medical Group, Inc., to examine and render treatment to my minor child/children at any time it is medically necessary. This authorization shall remain valid unless otherwise instructed by the parent/legal guardian.

Patient's Name

Patient's Date of Birth

Parent/Legal Guardian
(Print Name)

Relationship to Patient

Parent/Legal Guardian
(Signature)

Date of Signature

Witness