GAINESVILLE PEDIATRIC ASSOCIATES, INC.

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Permission to Treat

I, the parent/legal guardian of the below named child/children:

_____
Print childs/children's name

hereby authorize and consent to the examination and/or treatment of my child/children during office and facility visits by the physicians and clinical staff of Gainesville Pediatric Associates, Inc. In addition, I give permission for the following person(s) to bring my child to Gainesville Pediatric Associates, Inc. in my absence and to act in my behalf in authorizing medical care and treatment. In the event of emergency or other illness, I understand that the physicians and staff of Gainesville Pediatric Associates, Inc. will deliver any medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing, Gainesville Pediatric Associates, Inc. will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

I (we) authorize the following people to bring my child/children in for treatment:

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

Signature:_____ Date:_____