



Twelve Oaks Pediatrics

TODAY'S DATE: _____

PATIENT'S NAME: _____

DOB: _____

I confirm that I am 18 years of age or older and a legal adult. I hereby give my consent to Twelve Oaks Pediatrics, the doctors as well as the staff to discuss my medical care, lab work and treatments with the following:

I, _____, the parent/guardian of the above name child give permission for the following person(s) to seek medical care and treatment for him/her.

I can be reached by phone at _____. My signature below certifies my consent for examination and treatment of my child.

Name of Authorized Person

Name of Authorized Person

Parent/Guardian/Patient Signature

Date

Parent/Guardian/Patient Printed Name

Witness