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## Consent to Treat

I \_\_\_\_\_ authorize and accept  
(Full Name)

Best phone number where you can be reached: \_\_\_\_\_

### **Personal Care Pediatrics and its personnel to administer medical services**

In case of emergency, I authorize Personal Care Pediatrics to contact the following and may disclose any pertinent medical information to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_